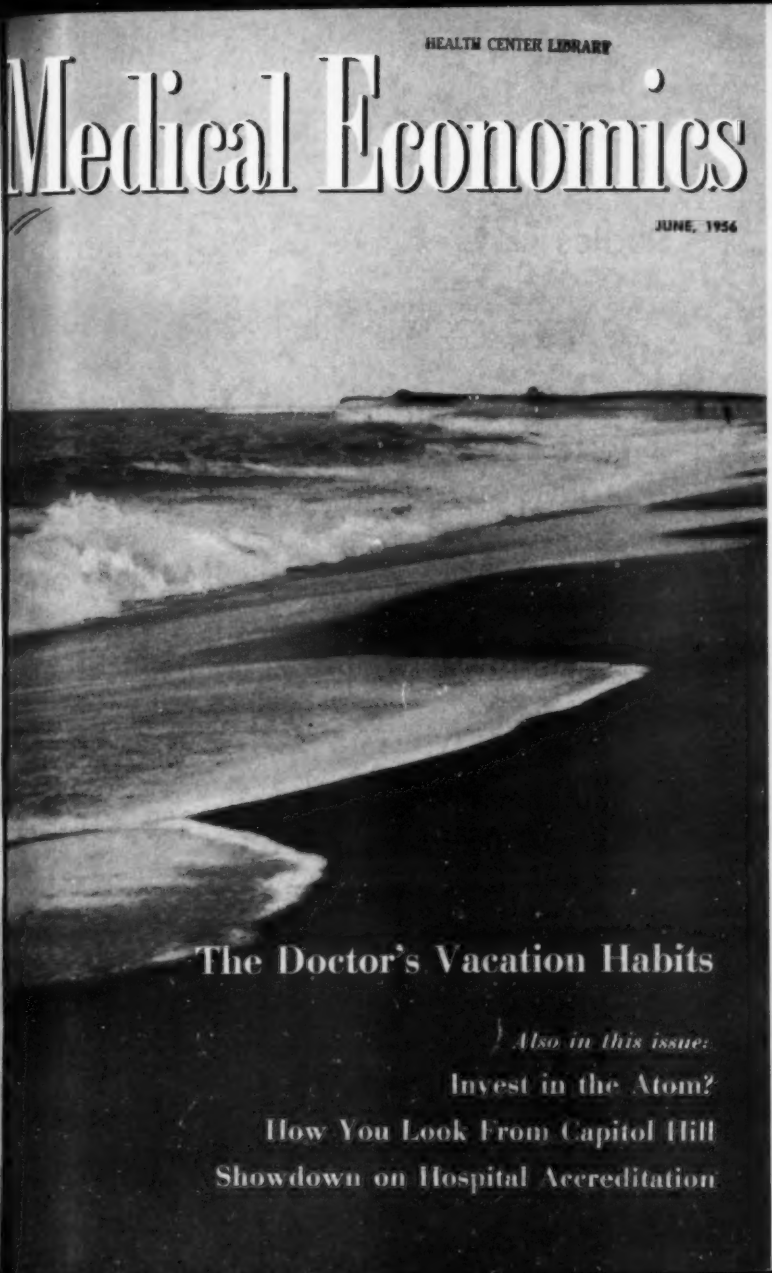
Medical Economics

JUNE, 1956



The Doctor's Vacation Habits

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Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JUNE, 1956

SPECIAL FEATURES

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clinically proved in many common infections[1-60]

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SPECIAL FEATURES (*Cont.*)

YOUR PRACTICE

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News

Should Blue Shield and Blue Cross Pay Taxes?

In most states, the Blue plans are still tax-exempt. But there's apparently some question as to how long they'll remain so. Now that they've grown into big businesses, some commercial insurers are beginning to label their tax-free status as "unfair competition."

Latest spokesman of the insurance industry to use that term: Buist M. Anderson, vice president of the Connecticut General Life Insurance Company. In a recent article in Best's Life News, he points out that though the Blue plans are nonprofit, they're "no more so than the mutual life insurance companies, which . . . pay large sums in [state and Federal] taxes." And, he adds, "the difference between a tax and no tax is too often the deciding factor in awarding the business [of large employe groups] to Blue Cross-Blue Shield."

Predicting an early end to such "subsidized competition," Anderson says: "The time is not far off when many states, sorely in need of revenue, will look to Blue Cross-Blue Shield for premium taxes. These taxes would place Blue Cross-Blue Shield on a par with the insurance concerns which write the other half of the business."

Forced Retirement Urged For Aging Surgeons

Are old surgeons a menace to patients? Not usually, says Dr. Bertram M. Bernheim, associate professor of surgery emeritus at Johns Hopkins; but he believes there *are* surgeons who practice beyond their endurance.

The public, he maintains, must be protected against such men—and against the possibility that *any*

surgeon over 60 might make an error at the operating table.

Trouble is, how can you provide such protection? "Older surgeons," Dr. Bernheim points out in a recent issue of The Modern Hospital, "do not give up operating generally speaking except for infirmity or illness . . . So you can't just walk up to a surgeon who in your judgment may have had bad results and say, 'Look here, my friend, you're getting old and your work at the operating table shows it. We think it's best . . . that you quit.' "

Bernheim

Some surgeons wouldn't listen to such a warning anyway, says 76-year-old Dr. Bernheim (who retired "voluntarily and not through disability" several years ago). They lack "the morality and sound judgment" to slack off voluntarily as they grow older. But he suggests that there *is* a way to shield the public from the dangers involved in the aging process:

Let every surgeon be "taken out of private practice and attached to the hospital as a salaried man . . . with insurance and proper pension . . . Under [such a] system medicine would operate exactly like industry in regard to its aging members. Surgeons would have physical examinations at yearly or other regular periods . . . If a man couldn't do certain work, he would be shifted to what he was able to do—or retired on pension . . . Under any circumstances, he would retire at an age period—like the military. For good; under pension."

Industry Seeks Better Medical Programs

Most companies now realize the value of industrial medicine. But are they satisfied with the kind of programs they're getting? Far from it, says Dr. Hardy A. Kemp, director of graduate studies at Baylor University's College of Medicine in Houston, Tex. In a recent issue of Industrial Medicine and Surgery, he points out a number of ways in which doctors could provide medical care more efficiently:

1. They could provide *cheaper* medical programs. "About a year ago," says Dr. Kemp, "I was showing an executive a copy of [a medical] examination . . . [It] was four pages, typewritten. It would print up into two. I was challenged: 'Doctor, show me one with *one* page. One page, five bucks;

Kemp

Snapshots

LIGHTER TAXES on higher incomes are now favored by most Americans, according to George Gallup. He says they think a $50,000-a-year family should pay about $7,000 in income taxes. Actual amount now paid: about $16,000.

LURE OF THE ISLANDS: Top officers of the Hawaii Medical Association this year are transplants from the mainland. Its president came from Iowa, its president-elect from Utah, its secretary from Oregon. And two of its centennial committee chairmen are natives of Nebraska and Sweden.

SPIRIT OF 1776 is being invoked to legalize "mercy killings." Exactly 1,776 doctors in New York State have signed a petition seeking voluntary euthanasia for incurables. Dr. James A. Corscaden, the group's head, hopes to get similar petitions circulating in other states.

FATHER'S FOOTSTEPS fit John D. Dingell Jr. He replaced his late father in the U.S. Congress—and promptly pushed for health legislation of the well-remembered Dingell type. First proposal: Free hospital care for everyone over 65.

four pages, twenty bucks.'... Life is real to that industrialist, and he challenges the medical profession to show him how $1,500 worth of physical examinations . . . will help him sell the equivalent net return in soda pop."

2. They could organize *better* medical programs. Among other things, industry apparently wants something more than routine physical examinations: It wants medical tests that relate to the demands of particular jobs. Dr. Kemp quotes one executive as saying: "Look, I want to know if these fellows can tote a barrel and lift a bale. I don't want a life insurance examination."

3. Medicine could "deliver a new kind of doctor—a physician whose interests and talents combine engineering and medicine, and whose bent for the economics of production is fully flavored with a true interest in the worker, his fellow man."

These are all important challenges, Dr. Kemp concludes. What they add up to, he warns, is the continuing—and growing—industrial need "for a workable form of preventive medicine."

The World Needs More Doctors, Says W.H.O.

Think your practice is too large? Actually, you've got one of the lightest patient-loads in the world.

according to Dr. J. L. Troupin of the World Health Organization.

"There are now 1,200,000 physicians in the world," he reports. That's apparently enough to supply one for every 2,000 people. But doctors are so unevenly distributed that twenty-two countries have only one physician per 20,000 or more inhabitants.

What countries have the most medical men per unit of population nowadays? The answer comes from Dr. Louis H. Bauer, secretary general of the World Medical Association. Here's his listing of the nations with the highest concentrations of physicians, together with the population-per-doctor of each country:

Israel	440
Austria	534
United States	760
Italy	762
Great Britain	775
Netherlands	866
Norway	880

Hospital Administrators Told to Study Doctors

Some hospital administrators are obsessed with the question, "How can I *make* my staff do this or that?" And in desiring to impose their will on the doctors with whom they work, such men are "displaying the undesirable trait of power-seeking." As a result, says Dr. Anthony J. J. Rourke, New Rochelle

Snapshots

52 MILLION AMERICANS now belong to Blue Cross. That's more than the number of automobile owners in this country, more than the number of home TV set owners.

WHAT DO YOU PAY your county medical society in dues? Commonest charges run under $5 in small societies, under $10 in large ones, the A.M.A. reports after surveying 1,225 areas. It could find only eight where county society dues run higher than $75 a year.

DOES PSYCHIATRY CONFLICT with religion? No, the two complement each other, says Dr. Kenneth E. Appel. He believes they can work together through the new National Academy of Religion and Mental Health, which he heads.

GRIEVANCE COMMITTEES, disturbed by legal threats from doctors who don't like their decisions, are pondering the protection provided by the Columbus (Ohio) Academy of Medicine. Its constitution says: "Membership in the Academy shall constitute a waiver of the rights to civil liability against any officer . . . or member of the Professional Relations Committee . . ."

(N.Y.) hospital consultant, they defeat their own goal of efficient administration.

Worried by their apparent shortsightedness, Dr. Rourke advises them, in a recent Hospitals magazine article, to mend their ways. The good administrator, he warns, must:

1. Have a "very clear and correct knowledge of the nature of the physician." Since good medical care depends primarily upon the "training, experience, and judgment of the doctor," the physician's traditional "rugged individualism" must be respected and preserved.

2. Refrain, therefore, from trying to change any staff doctor's nature. Instead, the wise administrator "will recognize it, accept it, and find ways of working with it."

3. Help the individual doctor to feel important. "Each member of the medical staff constantly desires to be important—first to his family, next to his patients, and always to his hospital . . . The best physician . . . will not [be happy] if he does not feel a part of, important to, and desired by his hospital."

Rourke

Whenever trouble starts within the staff of any institution, Dr. Rourke concludes, "you may rest assured that someone has failed to receive recognition and has interpreted it, not as neglect, but as active ingratitude."

'Labor May Strike for Better Health Plans'

Some observers think the danger of Government intervention in health insurance is receding. But one man with his ear to the ground—Harry Becker, the A.F.L.-C.I.O.'s leading adviser on health matters—isn't so sure.

Health insurance, he points out, has never yet "had top priority" as a bargaining issue between labor and management. And, in some ways, that's been fortunate: "It has enabled unions and employers, on one hand, and prepayment plans and the providers of services, on the other hand, to experiment with various approaches."

But things are about to change, avers Becker: "Within the next five to ten years . . . health benefits will become a top priority collective bargaining issue. When this occurs, all labor-management health programs throughout the country will begin to assume a more uniform pattern than exists today."

What's more, he predicts, the issue will be important enough to bring on "a major strike" if labor's demands aren't met. One such

demand is bound to be "full-employer financing of the health protection program . . . Making allowances for expansion of health benefit programs, it is reasonable to expect . . . that the employer's expenditures for health benefits will increase from 200 to 300 per cent or more over the next ten years."

If industry fails to provide such

He Doubles in Bronze

When Emil Seletz was a boy, he carved faces on trees with a pen knife. When he was 23—and a resident in neurosurgery—he suddenly had "an urge to learn sculpture." Since then, he's built himself two highly successful careers: one as chief of neurosurgery at Los Angeles' Cedars of Lebanon Hospital, the other as a widely known sculptor in bronze. He speaks modestly of his self-taught hobby as "dessert at the end of a meal." But, the fact is, seventeen of his works now stand in various public buildings across the country. He's built massive busts of men like Will Rogers and Beethoven; he's also done many medical figures like the six shown in the foreground above. From left to right, they are: Dr. Howard C. Naffziger, San Francisco neurosurgeon; Dr. Verne G. Hunt, late regent of the American College of Surgeons; Dr. Walter E. Dandy, professor of surgery at Johns Hopkins; Dr. Joseph P. Widney, late founder of the Los Angeles County Medical Association; Dr. Rachelle Seletz, who is in charge of rectal surgery at Cedars of Lebanon Hospital; and Dr. Caleb S. Stone, Seattle surgeon.

Clinical evidence[1,2,3]

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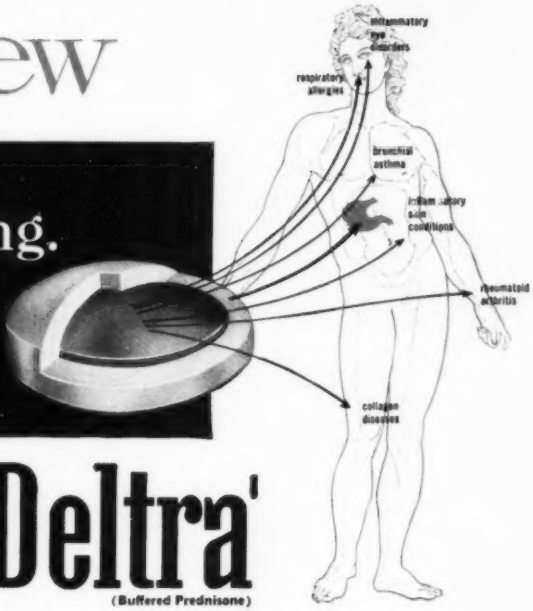

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expansion, then what? Well, says Becker: "Regardless of which political party [is in power], it will become increasingly feasible, politically, to propose government measures to strengthen the idea of prepayment."

Internes' House Calls Termed 'Unlawful'

Internes and residents in some areas are still picking up pocket money by making house calls. And the established physicians of one such place—Detroit—are trying to dissuade them by means of a mild rebuke wrapped in a strong promise.

In a letter to all local internes and residents, Dr. Milton R. Weed, secretary of the county medical society, has warned that the doctor-in-training who makes house calls is "subject to prosecution." Detroit medical men, he says, "strongly oppose this practice except when it is incorporated in an approved [training] program." Otherwise, it's "unlawful [and] inconsistent with a good educational program."

But the letter softens these stern words with a note of goodwill: "When you are ready to enter private practice, your county medical society will endeavor to help you get started. If, for example, you join [our] telephone service . . . your calls will be covered free of charge during your first three months of membership. The society receives approximately 3,000

calls monthly requesting names of physicians, and a proportionate share of these calls will be referred to you."

Patients Charged Fixed Hospitalization Fees

Will tomorrow's hospital bill be fixed in advance, regardless of the length of hospitalization? It's possible, if the current experiment of one California institution should start a trend:

The La Mesa Community Hospital now charges an inclusive rate for the hospitalization of several kinds of surgical, obstetrical, and gynecological cases; and it plans eventually to cover even more hospital cases in this manner.

Here are the cases now covered and fixed hospitalization costs (including everything but professional charges and the price of blood):

Appendectomy	$145
Cholecystectomy	265
Herniotomy, single	130
Herniotomy, double	145
Tonsils and adenoids	38
Caesarean section	160
Diagnostic dilation and curettage	30
Therapeutic dilation and curettage	40
Hysterectomy	225

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For the past several years, Roerig has cooperated with the Belgian chemists of Union Chimique Belge to develop Atarax®, a new and superior ataraxic. European clinical work on the compound has been exciting; literally thousands of case histories have been evaluated. Though clinical investigation of the product began in the United States only a year ago, an impressive number of papers are already being prepared here. All confirm the clinical benefits of Atarax: "peace of mind" induced faster, safer and with lower dosages.

The action of Atarax differs from that of older ataraxics. Specifically, Atarax is characterized by unique cerebral specificity, with central neuro-relaxation as the primary effect.

The "Ataraxed" individual maintains full consciousness of incoming stimuli which trigger his difficulties. He realizes their nature and their intensity, but his reaction becomes that of a well-adjusted person. He is neither depressed nor torpid because of Atarax. His reflexes remain normal, as does his cortical function. Entirely free from cerebral fogging, Atarax induces a calming, peace-of-mind effect without disturbing mental alertness. As you know, this point is extremely important to the patient who must adhere to a productive daily schedule.

Because of these advantages, Atarax should prove extremely useful in your daily practice. Consider, for example, its use in the tense businessman, the anxious geriatric, the hyperactive child, the menopausal female, the refractory ulcer case. Fabing, in fact, estimates that one of every four patients could benefit from ataraxic therapy.

Now, is Atarax safe? The toxicology of the drug has been remarkable. Test after test has shown it to be as safe as the placebo against which it was evaluated. No major toxicity on liver, blood or brain is reported, and no

parkinsonian effects. In geriatrics and in children, the drug has been given especial rigorous investigation. Again, no untoward effects, such as nausea or diarrhea, can be defined.

A slight drowsiness has been reported in some cases. This may very well be a normal state, since the patient, relieved of his tension and anxiety during the day, may be prepared to fall asleep easily and naturally in the evening. However, less than 15% of patients report this effect, and it has not been considered a drawback by the investigators.

You may appreciate another significant Atarax advantage, Doctor: its ready onset of action. Unlike reserpine-type drugs, Atarax will begin to calm tense patients within fifteen minutes. Maximum therapeutic effect is generally reached within two hours, gradually abates, and usually disappears after 6 to 20 hours.

Efficacy, of course, is the extremely important point. As of this writing, it appears that Atarax is effective in from 80% to 90% of all tense patients. Being specifically an ataraxic for the "more normal" patient, however, Atarax is not recommended for use in psychotics or the hospitalized insane. When its use produces limited response, the psychiatric status and the diagnosis should be carefully reevaluated to be sure that one is not confronted with a malignant nervous condition, or a basic organic condition. Encouraging reports on Atarax are now being received on its use in psychogenically-related states (such as eczema, allergy, asthma), but the sizes of the series are not yet large enough statistically for us to report on. The same is true for children under 6.

We have devised a new distribution technique to make certain that your Atarax prescriptions can be filled. Every drugstore in the United States has now received an initial supply of tablets, and steps have been taken to make sure that supplies do not run short. For real peace of mind for your tense patients, prescribe Atarax in the following recommended dosages:

Adults: usually one 25 mg. (green) tablet, t.i.d.
Children: usually one 10 mg. (orange) tablet, twice daily. Adjust as needed, according to patient's response.

Sincerely,

Thos. J. Winn
President

set up? Here's how John H. Gorby, administrator of the La Mesa hospital, explains it:

"The most unpredictable cost of illness since time immemorial has been the cost of hospitalization . . . This uncertainty is not good."

La Mesa feels that its pioneering program of all-inclusive rates "regardless of length of stay, based on average costs and calculated on statistically sound formulas," is worth trying simply because it relieves the patient's mind of such uncertainty.

Of course, Gorby concedes, the plan presents problems. Drugs may be used excessively, for instance; or patients may be kept in bed longer than necessary. But the hospital minimizes these complications by means of its "strong" medical records committee. The committee meets often and examines the clinical records of all patients. If a patient seems to have been hospitalized for an undue period, his doctor is asked for an explanation.

Prescription Writing Gathers Pace

The average American physician wrote ninety-five more prescriptions in 1955 than in 1954, according to American Druggist magazine's latest survey of prescription trends. One obvious reason for the

In Hypertension

To lower the tension

and **Stabilize** it...

Rauwiloid® + Veriloid®

For moderate to severe hypertension. The combination permits long-term therapy with lower doses of Veriloid, greatly lessened side effects, and dependably stable response. Each tablet contains 1mg. Rauwiloid and 3mg. Veriloid. Initial dose, 1 tablet t.i.d., p.c.

Rauwiloid® + Hexamethonium

For severe, otherwise intractable hypertension, this single-tablet combination provides smoother, less erratic response to oral hexamethonium, thereby stabilizing reduced tension. Permits up to 50% less hexamethonium to exert full effect. Each tablet contains 1mg. Rauwiloid and 250mg. hexamethonium chloride dihydrate. Initial dose, ½ tablet q.i.d.

Synergistic

Better Tolerated

Combination Therapy

Riker

LOS ANGELES

increase: Drug firms gave the doctor more new products to work with.

The survey reveals that the total number of prescriptions filled (including renewals) jumped to a whopping 482,190,000 last year. This figure reflects a 30 per cent increase over the prescriptions written in 1948, the year in which American Druggist made its first such survey.

The magazine attributes much of the increase in prescription writing to a flood of new pharmaceutical items. It cites a reliable estimate (from Paul de Haen, former vice president of the Ames Company) that 403 such items were marketed in 1955, as against only 380 in 1954.

The same general uptrend extended to prices. The average prescription charge last year was $2.68 —an increase of 5.9 per cent over 1954. Average prices for the five top-volume product types: anti-infectives (internal), $3.57; sedatives and hypnotics, $1.88; cardiovasculars, $3.36; anti-spasmodics, $2.37; and analgesics (internal), $1.92.

Student A.M.A. Grows

If organization membership is a valid criterion for comparing different generations of physicians,

student doctors are putting their elders to shame.

The Student A.M.A., it seems, boasts four out of every five of the country's 30,000 medical students as members. By contrast, the A.M.A. has only a little more than three-fifths of the nation's 200,000-odd doctors in its fold.

Now five years old, the student association has chapters in seventy-two medical schools and is forming new ones right along. What's more, reports executive secretary Russell F. Staudacher, it's driven the left-wing Association of Internes and Medical Students almost out of business.

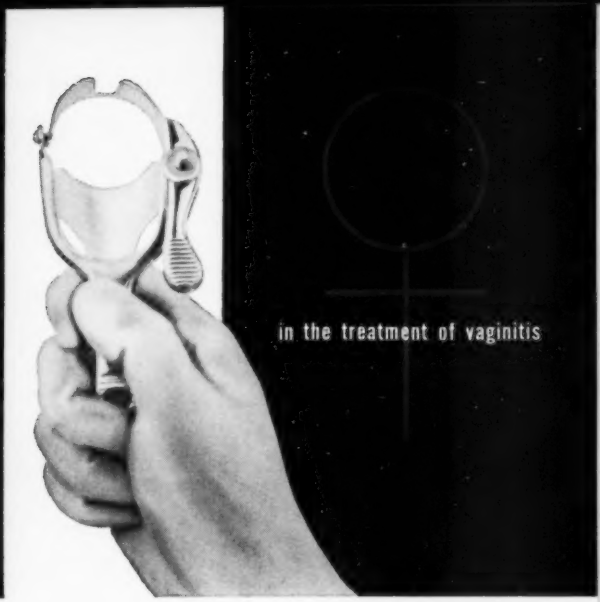
What is the Student A.M.A. doing to make its existence worthwhile?

For one thing, it provides a shrewd evaluation of hospital internships. For another thing, it's just recently established a national loan foundation from which needy students will be able to get annual loans of up to $1,500.

Fee Scale Set for G.P.s Assisting at Surgery

You may recall the recent dispute at St. Joseph's Hospital in Milwaukee over adoption of the so-called Columbus plan. [See News, MEDICAL ECONOMICS, January, 1956.] Under that plan, [MORE ON 239]

IN ADVANCE



in the treatment of vaginitis

new . . . simple . . . effective . . . topical therapy

Clinical evidence shows Sterisil Vaginal Gel to be highly effective not only against Trichomonas and Monilia, but against the newly discovered pathogen *Hemophilus vaginalis* (now believed to be the etiologic organism most frequently responsible for so-called "nonspecific" vaginitis and leukorrhea).*

High tissue affinity of Sterisil assures prolonged antiseptic action; vaginal secretions are less likely to remove Sterisil from the site of application. Sterisil is also more convenient for the patient. Fewer applications are required for successful treatment.

Acceptable to patients, Sterisil Vaginal Gel is easily applied, won't leak or stain, requires no pad. Signs of local or systemic toxicity or sensitization have not been reported.

Dosage: One application every other night until a total of 6 has been reached. This treatment may be repeated if necessary.

Supplied in 1½ oz. tube with 6 disposable applicators. Instructions for use are included with each package.

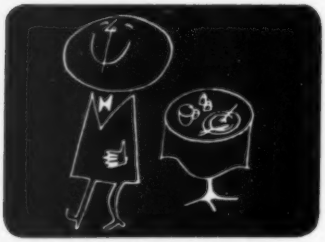
*Gardner, H. L., and Dukes, C. D.: Am. J. Obst. & Gynec. 69:962 (May) 1955.

STERISIL® VAGINAL GEL

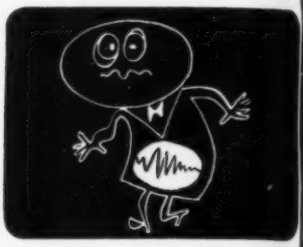
Brand of hexetidine

WARNER-CHILCOTT

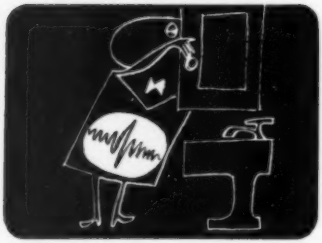
shortest distance to relief via the **AL-CAROID** route



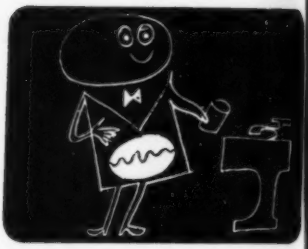
All's right with the inner man.



Whoops! Storm's a'brewin'!



Al-Caroid to the rescue.



Like Doctor says — Al-Caroid works!

Thanks Doctor! Thanks Al-Caroid!

Supplied in tablet or powder form.

Al-Caroid® is more than "just an antacid"

Its effective acid neutralizing properties provide a plus feature with its Caroid content. Caroid, a proteolytic enzyme, is effective in both acid and alkaline media.

Al-Caroid is a natural for your dyspeptic patients who require both antacid and protein digestant aid for full relief from heartburn, flatulence and general digestive upsets.

Trial supply available upon request.

American Ferment Company, Inc. • **1450 Broadway** • **New York 18, N.Y.**

Report | from Carnation Research Laboratory

Scientific Staff Conferences

Regular conferences of the entire research staff are held so that the pooled knowledge of these highly qualified men may establish broad general directions for major research projects. Such conferences also keep the entire staff informed of current progress in all six major research divisions.

Continuous, Planned Research

protects the optimum high quality and uniformity of both established and new Carnation food products.

6 Research Divisions

Carnation general research projects are conducted under six major laboratory divisions: three Dairy Product Laboratories, the Nutrition Laboratory (chemical and biochemical), the Cereal Laboratory and the Analytical Laboratory.

Carnation Protects Your Recommendation with Continuous 5-Phase Research:

Carnation Research Laboratory; Carnation Farms; Carnation Plant Laboratories; Carnation Central Product Control Laboratory; Carnation-sponsored University & Association Research.

"from Contented Cows"

magnified potency

with Meti-steroid

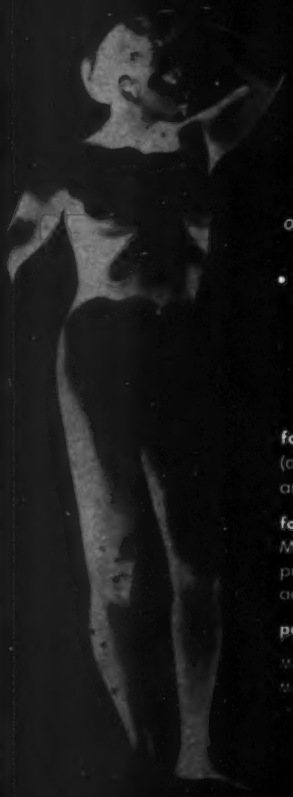
effectiveness in allergic

and inflammatory dermatoses

new

Meti-Derm cream 0.5%

with METICORTELONE, original brand of prednisolone



- *approximately*

twice the per milligram

anti-inflammatory activity

of topical hydrocortisone

- *cosmetically acceptable*
- *water-washable*

for effective local relief of allergic (atopic and contact) dermatoses, nonspecific anogenital pruritus.

formula: Each gram of water-washable METI-DERM Cream contains 5 mg. (0.5%) of prednisolone, free alcohol, in a cosmetically acceptable base.

packaging: METI-DERM Cream, 0.5%, 10 Gm. tube.

METI-DERM ® brand of prednisolone topical.
METICORTELONE ® brand of prednisolone.

...and adding dual control

to Meti-steroid skin therapy—

protection

against infection

new

Meti-Derm ointment

with Neomycin

enhanced effectiveness

in allergic, inflammatory

dermatoses when

minor infection

is present

or anticipated

neomycin in addition to prednisolone, free alcohol—for protective coverage against virtually all pathogenic skin bacteria with a well-tolerated, *topical* antibiotic.

formula: Each gram of water-washable METI-DERM Ointment with Neomycin contains 5 mg. (0.5%) prednisolone, and 5 mg. (0.5%) neomycin sulfate equivalent to 3.5 mg. neomycin base.

packaging: METI-DERM Ointment with Neomycin, 10 Gm. tube.

Schering

MD-J-656

At Last...

UNIFORM DOSAGE NEBULIZATION in Asthma

MEDIHALER™

with your favorite Bronchodilator*

- NO RUBBER BULBS TO DETERIORATE
- NO BREAKAGE OF COSTLY GLASS NEBULIZERS
- NO SPILLING OF SOLUTION IN POCKET OR PURSE

True nebulization—80% of particles measure from ½ to 4 microns radius. • Dose released always the same—does not depend on pressure applied. • One application usually sufficient for most patients.

Medihaler Oral Adapter is unbreakable. Vial of medication is shatterproof, leakproof; provides 200 applications. Economical. Safe for use with children, too.

One application usually aborts attack.

*** MEDIHALER-EPI™**
Riker brand of 0.5% epinephrine HCl U.S.P. in aerosol solution

*** MEDIHALER-ISO™**
Riker brand of 0.25% isoproterenol HCl U.S.P. in aerosol solution

On your prescription be sure to write "Medihaler-Iso (or Medihaler-Epi) AND Medihaler Oral Adapter," since medication cannot be used without Adapter. For refills write for medication only.

Another First from Riker LOS ANGELES

New Relief from the Enigmas of Pruritus Ani

CASE – MALE, 55 YEARS

BEFORE

Rectal itch for 20 years; itching in rectal area extending across perineum to scrotum in wide area. Red scratches in perineal region. Severe erythema. Areas sensitive, painful, tender

Hydrolamins Ointment, an isotonic, specially selected combination of amino acids, offers a new answer to the baffling problem of ano-genital pruritus.

Therapy is based on the observation[1,2,3] that this non-irritating protein counteracts the protein-precipitating irritant responsible for the pruritus and is protein-sparing to perianal tissue.

AFTER

Hydrolamins applied 3 times daily to whole area. No irritation developed. Itching relieved immediately, and healing was complete in three weeks.

FORMULA:

Hydrolamins offers an isotonic, specially selected combination of amino acids derived from lactalbumin, in a vehicle of polyethylene glycol 1500.

SUPPLIED:

1 oz. (28 Gm.) and 2.5 oz. (70 Gm.) tubes with peel-off label.

Lewal PHARMACEUTICAL COMPANY CHICAGO 14, ILLINOIS

REFERENCES:

1. Bodkin, L.G. Amino Acid Therapy for Pruritus Ani. Am. J. Surg. 82:557 (Nov.) 1951.
2. Bodkin, L. G., and Ferguson, E. A., Jr. Successful Ointment Therapy for Pruritus Ani. Am. J. Digest. Dis. 18:59 (Feb.) 1951.
3. McGivney, J. Recent Advances in Proctology. Texas J. Med. 47:770 (Nov.) 1951.

Primum Non Nocere

The primary concern of the dermatologist is embodied in the dictum, "Primum Non Nocere," meaning "*First do no harm.*"[1,2]

A major attribute of Desitin Ointment is its non-sensitizing, non-irritant, non-toxic[4-6] quality even when applied over extensive, raw skin areas. To soothe, protect, lubricate, and accelerate healing ... without causing "therapeutic" or "overtreatment" dermatitis ... rely on

DESITIN®

OINTMENT

rich in **cod liver oil**

in **diaper rash • wounds** (especially slow healing)
ulcers (decubitus, varicose, diabetic) **• burns**
dermatoses • rectal irritation

Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.

May we send **samples** *and literature?*

DESITIN CHEMICAL COMPANY Providence, R. I.

1. Overall, J. C.: Southern M. J. 47:789, 1954. 2. Editorial: New England J. M. 246:111, 1952.
3. Grayzel, H. G., Heimer, C. B., and Grayzel R. W.: New York St. J. M. 53:2233, 1953.
4. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
5. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
6. Turell, R.: New York St. J. M. 50:2282, 1950.

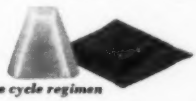
89.9% *of patients free from trichomoniasis in one menstrual cycle*

This receptionist's symptoms of local itching and burning are gone, due to her doctor's thorough powder insufflation and her own use of suppositories at home.

- *many cases refractory* to previous therapies responded to TRICOFURON *combined* therapy in 4 clinical studies of 108 patients.* Cure rate was 89.9%
- *advantages:* contains a specific, trichomonacidal nitrofuran. Kills many secondary invaders but permits essential Döderlein's bacillus to exist. Effective in blood, pus and vaginal debris
- *office treatment:* insufflate TRICOFURON Powder twice the first week and once a week thereafter
- *home treatment:* first week—the patient inserts one TRICOFURON Suppository each morning and one each night at bedtime. Thereafter: one a day—a second if needed

Suppositories contain 0.25% Furoxone® (brand of furazolidone) in a water-miscible base. Hermetically sealed in green foil. Box of 12. Powder contains 0.1% Furoxone in water-soluble base composed of lactose, dextrose and citric acid. Bottle of 30 Gm.

*Personal Communications to Medical Department, Eaton Laboratories. Detailed information on request.



one cycle regimen

TRICOFURON

t. m.

VAGINAL SUPPOSITORIES AND POWDER

EATON LABORATORIES, Norwich, N. Y.

NITROFURANS a new class of antimicrobials, neither antibiotics nor sulfas

EXPASMUS RELIEVES TENSION

Expasmus® provides safe, effective *clinically evaluated* therapy without the disadvantages of belladonna, the barbiturates or amphetamine.

Expasmus relieves the tension associated with muscle spasm, pre-menstrual and anxiety states . . . relieves pain and muscle spasm in arthritic and rheumatic conditions . . . relieves low back pain.

A modern, comprehensive, single prescription therapy.

Composition and dosage: Each Expasmus tablet contains dibenzyl succinate, 125 mg., mephenesin, 250 mg., salicylamide, 100 mg. In bottles of 100. Average dose: Two tablets every four hours; in resistant cases, three tablets four times a day.

On prescription only, samples on request.

MARTIN H. SMITH COMPANY

131 East 23rd Street, New York 10, N.Y.

Manufacturers of ethical products for over half a century.

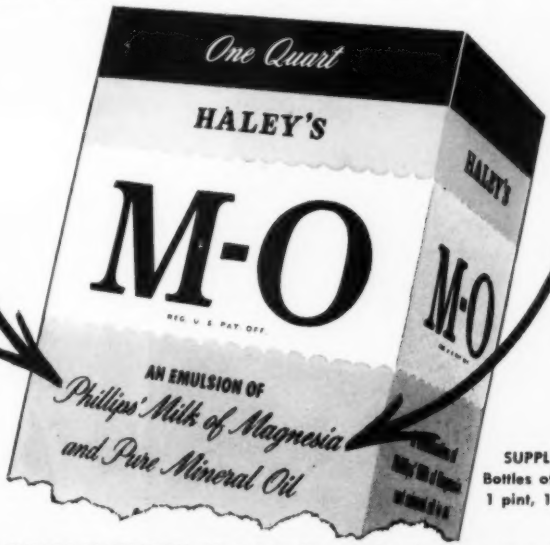
NOW...
also in Delightful
FLAVORED
FORM

Smooth-Working Combination

TO HELP CORRECT CONSTIPATION
Antacid • Laxative • Lubricant

Magnesium Hydroxide plus pure mineral oil make Haley's M-O a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and the attendant gastric hyperacidity.

The oil globules in Haley's M-O are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is avoided and a comfortable evacuation is effected through stimulation of normal intestinal rhythm and blunted defecation reflex.

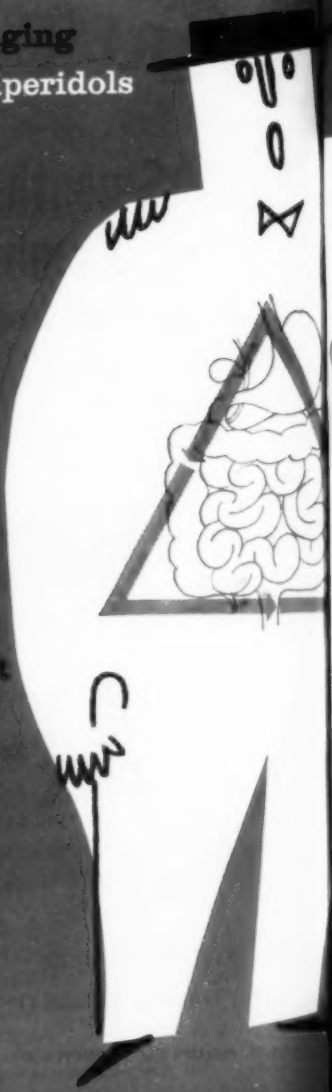


SUPPLIED:
Bottles of 8 oz., 1 pint, 1 quart.

THE CHAS. H. PHILLIPS CO. DIVISION *of Sterling Drug Inc.* **1450 Broadway, New York 18, N. Y.**

makes them feel like singing

three patients . . . three piperidols



for generalized

G. I. dysfunction

TRIDAL

DACTIL and PIPTAL

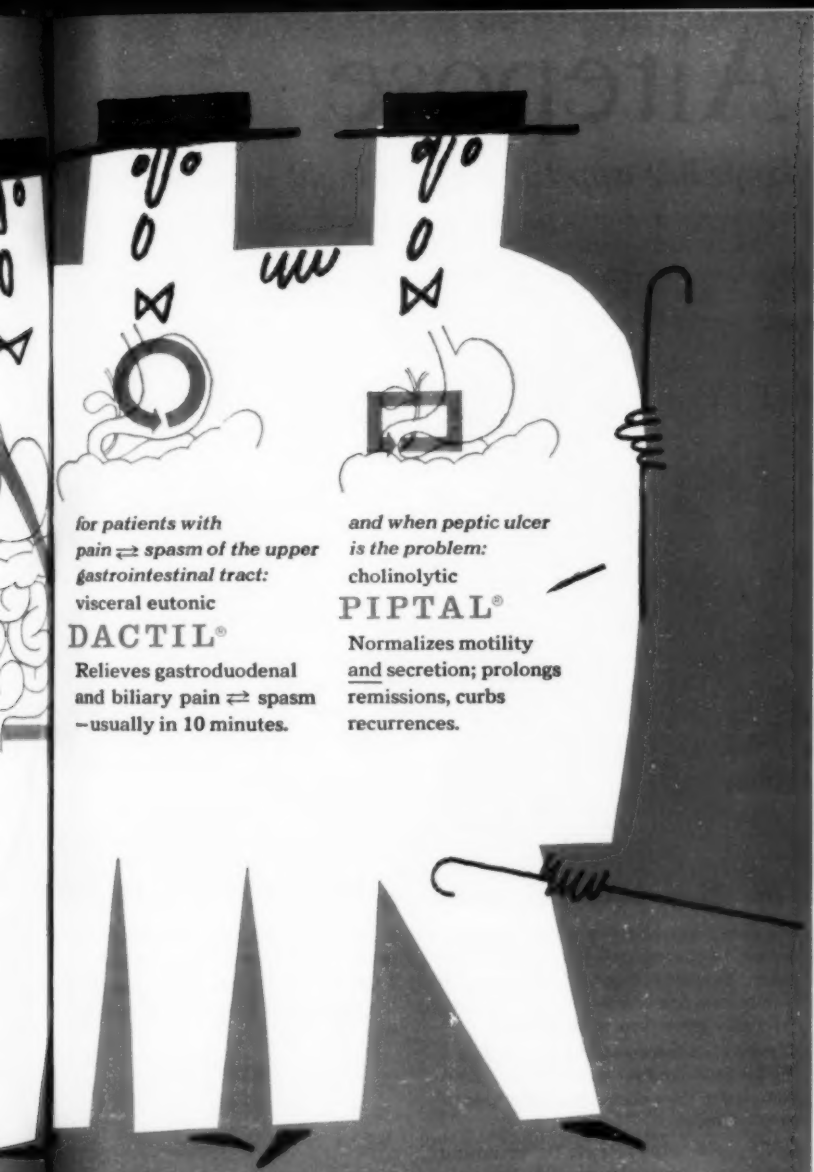
paired piperidol action

rapid, prolonged relief

throughout the G. I. tract

Provides *comprehensive* control—relief of pain and spasm PLUS normalization of motility and secretion in generalized gastrointestinal dysfunction.

LAKESIDE



for patients with pain ⇄ spasm of the upper gastrointestinal tract:
visceral eutonic

DACTIL®

Relieves gastroduodenal and biliary pain ⇄ spasm –usually in 10 minutes.

and when peptic ulcer is the problem:
cholinolytic

PIPTAL®

Normalizes motility and secretion; prolongs remissions, curbs recurrences.

...on TRIDAL, DACTIL or PIPTAL remain singularly free ...ary retention, constipation, dry mouth, blurred vision.

Altepose.®

keeps her appetite—and weight—under contro

MAJOR ADVANTAGES: 1. Overcomes excessive craving for food. 2. Reduces tissue water retention. 3. Alleviates nervousness and irritability.

It's much easier for your overweight patient to pass up rich food—when she's taking ALTEPOSE. For ALTEPOSE contains 3 important ingredients which help overweights stay on their reducing diets.

1. *Propadrine*® controls the patient's craving for food—and yet it causes less central stimulation than does either ephedrine or amphetamine.

2. *Thyroid* helps release tissue-bound water—thus brings about weight-loss *early* in the dieting period.

3. *Delvinal*® relieves the irritability so often associated with rigid diets.

Each ALTEPOSE Tablet contains 50 *mg.* 'Propadrine' HCl, 40 *mg.* thyroid and 25 *mg.* 'Delvinal.'

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

Letters

Surgical Qualifications

SIRS: The title of a recent article asked, "What Qualifies a Doctor to Do Surgery?" I can give at least a partial answer:

No man has any right to call himself a surgeon until he's had at least five years of general practice. Such experience should be made compulsory. The specialty today has too many money-mad misfits who haven't had enough old-fashioned family doctor experience to give them a little human understanding.

Vincent Bonfiglio, M.D.
Los Angeles, Calif.

SIRS: There are many arguments in favor of requiring a man to do some general practice before specializing. The only trouble is, this would add even more years of hardship to the long training period. I wouldn't be surprised, if the present trend continues, to see men with long white beards just starting out in neurosurgery.

John F. Friery, M.D.
Bergenfield, N. J.

SIRS: I hope that Dr. John S. DeTar didn't mean it when, as quoted in your article, he said: "All I do is tonsils; but that isn't really surgery." If he *did* mean it, he's the victim of an exceedingly dangerous fallacy.

Tonsillectomy and adenoidectomy are two of the most commonly performed operations today. Yet, more frequently than any other operations, they're attended by such troublesome and serious complications as cardiac arrest, atelectasis, and postoperative hemorrhage . . .

J. B. Gregg, M.D.
Sioux Falls, S. D.

SIRS: As chief of staff in a community hospital, I have this to say:

she came for a check-up...

treat her ACNE, too

When teen-agers come to you for any reason—treat that acne, too.

They may be too self-conscious to seek your advice but—to prevent permanent scarring—their acne demands early treatment under your skilled supervision.

ACNOMEL* CREAM

the most widely prescribed acne preparation

Also available: 'ACNOMEL' CAKE (½ strength)

- brings rapid improvement, often in days
- quickly lifts patients' morale, gains their cooperation
- is virtually invisible when applied
- contains sulfur-resorcinol-hexachlorophene

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

If I ever heard a staff member make such a statement, he'd never again do a tonsillectomy—or, for that matter, *any* surgery—in our hospital . . .

G. Brooks West Jr., M.D.
Cambridge, Md.

Dr. DeTar writes: "Kudos to Doctors Gregg and West for picking up a misleading statement that was uttered in jest but somehow didn't come out that way in print. I was discussing the granting of major surgical privileges to physicians who have demonstrated their competence.

"Naturally, tonsillectomies—like all other surgical procedures—shouldn't be performed by any doctors who have not proved that they're fully qualified."—ED.

Labor's 'Hirelings'

SIRS: It seems to me that your article "Will You Soon Be a Hireling of Labor?" is calculated to produce animosity and fear in an area where mutual understanding and trust are essential.

The evidence that doctors are becoming "hirelings" of union-management trusteeship is flimsy, to say the least. In eight years of working with unions, I've almost never seen any reason to believe that the union leaders' goal is more power. Clearly, their aim is to se-

cure the best possible health service for their members . . .

In order to anticipate probable costs and to determine the actual extent of coverage, unions *must* encourage their members to go to physicians who have agreed to follow stabilized fee schedules . . .

E. Richard Weinerman, M.D.
El Cerrito, Calif.

Hospital Administrators

SIRS: In a recent Letters column, one of your readers says: "Most of the hospital administrators I know stay up nights trying to find ways to improve patient care."

It's my impression that *doctors* are supposed to be in charge of patient care. Or is that idea old-fashioned, as the modern administrator sees it?

If any administrator wants to stay up late, I suggest that he do so *in the hospital*, checking up on how employes rightfully under his jurisdiction are doing their jobs.

Duncan C. McKeever, M.D.
Houston, Tex.

Doctor-Lawyer Codes

SIRS: Your article "*Must* Doctors and Lawyers Be at Odds?" mentions that Oregon has a state-wide code for cooperation between the two professions. In establishing this code, we hoped it would settle most medico-legal difficulties. It has done just that.

Subpoenas are almost never served on Oregon physicians nowadays. Attorneys and judges are

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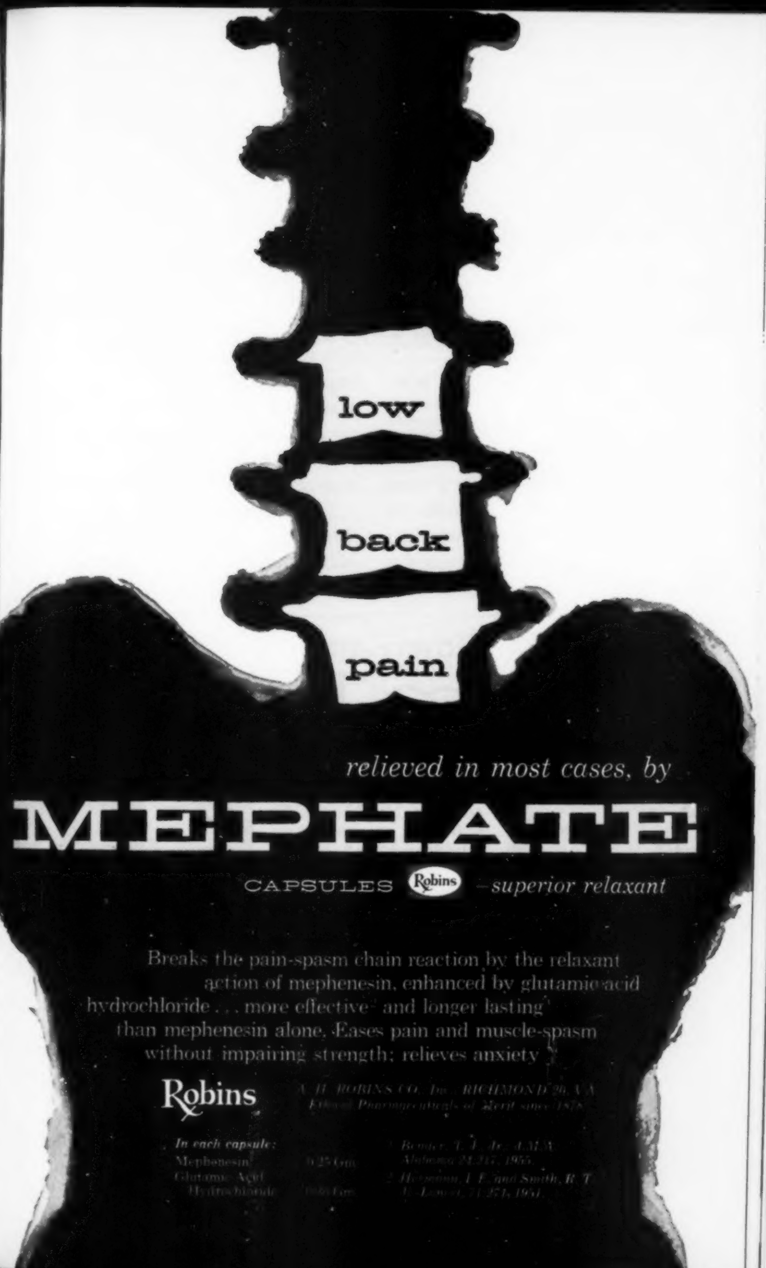


extremely considerate of the doctors' time. In return, we try to provide prompt, informative reports and to be punctual and cooperative when called as witnesses.

. . . This code has led to a more pleasant and efficient cooperation in the public service. It has also created better public relations for both professions.

E. G. Chuinard, M.D.
President
Oregon State Medical Society
Portland, Ore.

SIRS: I'm not sure there's a vital need for doctor-lawyer codes in many areas. In Pennsylvania, no such code exists, to the best of my knowledge. Yet interprofessional relations in this state are quite generally excellent . . .

Harold B. Gardner, M.D.
Secretary-Treasurer
Medical Society of the State of Pennsylvania
Harrisburg, Pa.

Offices in Hospitals

SIRS: The article "Doctors Take to Offices in Hospitals" deals mainly with general hospitals. In these, the emphasis is primarily on private practice . . . But in the large teaching centers, private practice facilities are provided largely in exchange for the staff member's time.

The hospital sets up a point system based on the number of hours each doctor devotes to clinic responsibilities, research, etc. This

FROM ONE OF THE THOUSANDS
OF ANSOLYSEN CASE RECORDS

In Complicated Essential Hypertension

CASE SUMMARY

CASE SUMMARY

CASE SUMMARY

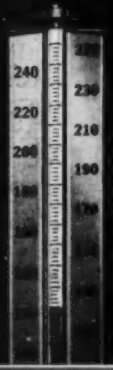
PATIENT: W. T., a 55-year-old male.

DIAGNOSIS: Essential hypertension of more than 2 years' duration with chronic congestive heart failure. Grade II fundi.

TREATMENT: ANSOLYSEN (q.i.d.) plus reserpine (0.25 mg. q.i.d.).

RESPONSE: Blood pressure dropped to normal or near normal levels when the effective dose of ANSOLYSEN was reached (March, 1955). Diuresis occurred promptly, and the patient lost 15 pounds within one week. "This was associated with marked clinical improvement, and obviated the need for mercurial diuretics which, prior to the control of blood pressure, were required once or twice weekly."[1]

REPORTED BY: 1. Sheldon, M. B.: Am. Pract. & Dig. Treat. 7:33 (Jan.) 1956.



Supplied: ANSOLYSEN Tablets, 20 mg., 40 mg., and 100 mg., scored, bottles of 100. ANSOLYSEN Injection, 10 mg. per cc., vials of 10 cc.

ANSOLYSEN®

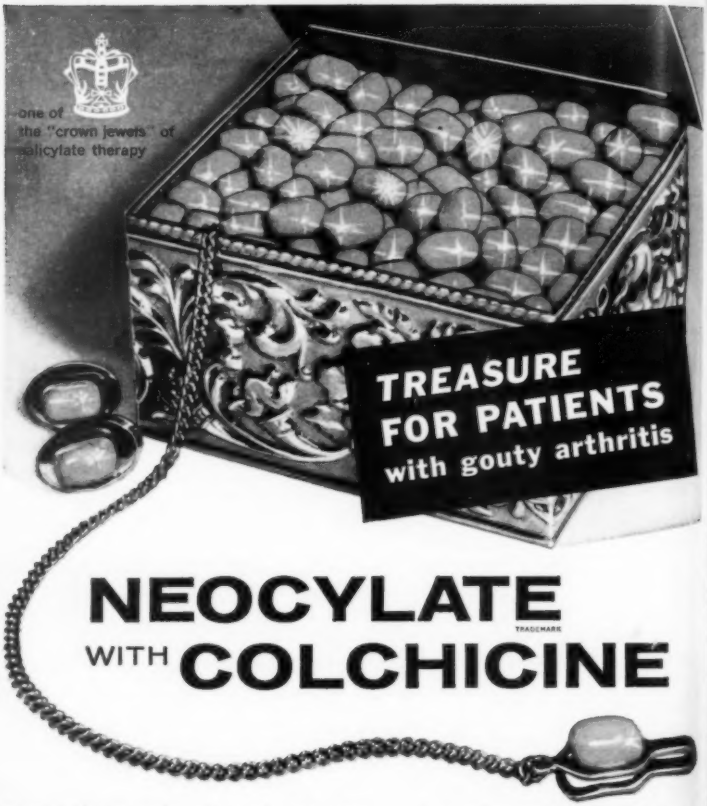
TARTRATE

Pentolinium Tartrate

Wyeth

Philadelphia 1, Pa.

LOWERS BLOOD PRESSURE



NEOCYLATE TRADEMARK WITH COLCHICINE

Unites the specific value of colchicine for diagnosis and treatment of gout with the dual action of salicylate as analgesic and uricosuric agent. NEOCYLATE with COLCHICINE is one of the "crown jewels" of Central's family of potentiated salicylate products.

Each enteric-coated tablet contains:

Sodium Salicylate	0.25 Gm. (4 gr.)
Para-Aminobenzoic Acid	0.25 Gm. (4 gr.)
Ascorbic Acid	20 mg. (1/3 gr.)
Colchicine	0.25 mg. (1/250 gr.)

Supplied: Bottles of 200, 500 and 1000 yellow tablets.

Literature on Request

THE CENTRAL PHARMACAL COMPANY
Products Born of Continuous Research
SEYMOUR, INDIANA

point system determines priorities in filling office vacancies.

William Amols, M.D.
New York, N. Y.

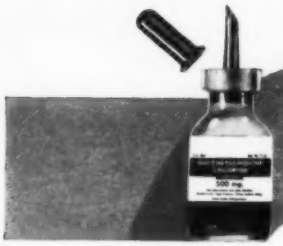
SIRS: Any hospital that provides private practice offices tends to promote the closed-staff system and to be unfair to the general practitioner. I consider the idea as another step toward hospital control over the practice of medicine.

Walter D. Abbott, M.D.
Des Moines, Iowa

Toward Fairer Fees

SIRS: Early this year, a patient who was covered by Ohio Workmen's Compensation came to my office for a dressing. I sent a claim for $5 to the industrial commission of that state. They replied that their fee schedule wouldn't allow more than $3 for such a service. This, I argued, would pay only for the use of my office facilities—nothing at all for my services. But of course I got nowhere.

Then I began wondering just how much it *did* cost me to treat each patient. So I counted up all the names appearing on my appointment lists last year and divided that number into the total cost of running my office. I was surprised to find that every time a patient walks into my office *he* costs *me* $4.63. [MORE ▶



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the only one-step sterile additive vial
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AUTOMATIC—NO AMPULES, NEEDLES, SYRINGES

You just remove tamperproof tip and push sterile plug-in through large hole in stopper of solution bottle. Pressure differential causes drug to be drawn into solution bottle instantly and automatically.

EXCLUSIVE HOSPITAL-USE FEATURES

Saves Time—Makes possible instantaneous automatic supplementation of bulk parenteral solutions.

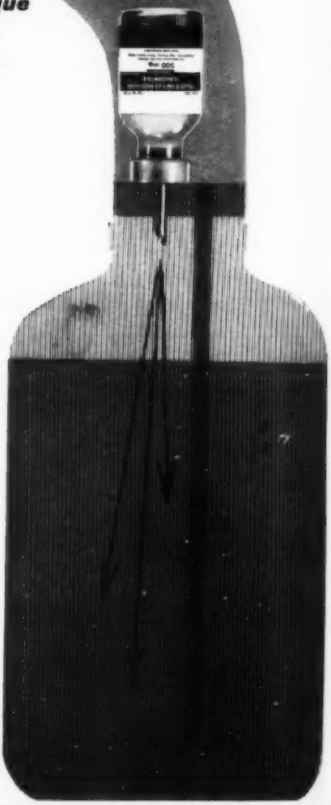
Saves Money—No needles, syringes or ampules required. Reduces preparation time, labor and expense.

Permits Sterile Technique—Gives complete protection at preparation stage... permits uninterrupted sterility. INCERT contents never exposed to air.

Easier to Use—The INCERT vial is a one-step parenteral additive unit, so simple compared with conventional methods.

NOW AVAILABLE IN INCERTs

SUCCINYLCHOLINE CHLORIDE 500 and 1000 mg. in sterile solution
TRINIDEX-C B Vitamins with 500 mg. Vitamin C
POTASSIUM CHLORIDE 20 and 40 mEq. in sterile solution
POTASSIUM PHOSPHATE 30 mEq. K^+ and $HPO_4^=$ in sterile solution
CALCIUM LEVULINATE (10% solution) 6.5 mEq. Ca^{++} in sterile solution



TRAVENOL LABORATORIES, INC.

PHARMACEUTICAL PRODUCTS DIVISION • **BAXTER LABORATORIES, INC** • MORTON GROVE, ILLINOIS

If all doctors would take time to figure their costs in this way, maybe we could enforce our demands for more realistic fee schedules.

M.D., Pennsylvania

G.P. Matters

SIRS: It's time we debunked the idea that G.P.s are "specialists" in the treatment of acute and chronic, medical and surgical diseases of men, women, and children. Remember that old phrase, "Jack of all trades, master of none"?

W. O. Quiring, M.D.
Hutchinson, Kan.

SIRS: "The G.P.s are done for! They'll soon take their place in the glass-enclosed cage next to the dodo," writes one of your correspondents.

Nonsense! *Someone* has to see the sick man first; and that man will continue to be the G.P., as long as his community has confidence in him . . .

M.D., Idaho

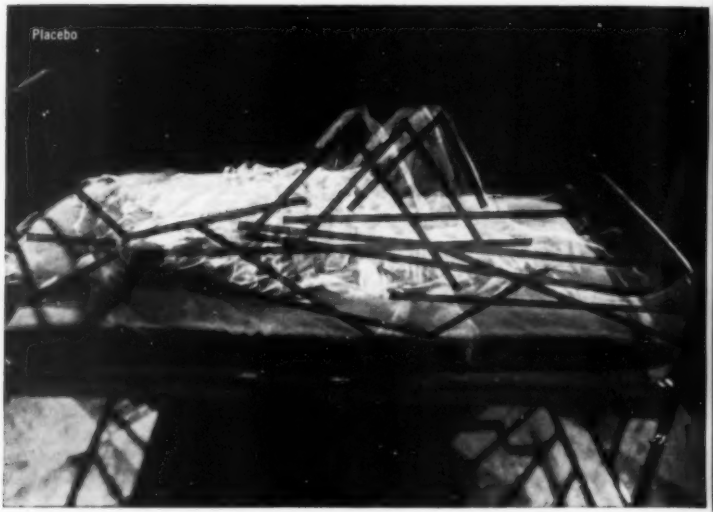
SIRS: The only way the G.P. can make sure his surgical patient will get expert care and efficient consultation at a reasonable price is to send him to the Mayo Clinic or some similar institution. If, instead, he sends him to a local surgical specialist, the poor patient will be bounced from internist to urologist

through-the-night photographs show...

NONBARBITURATE

Doriden®

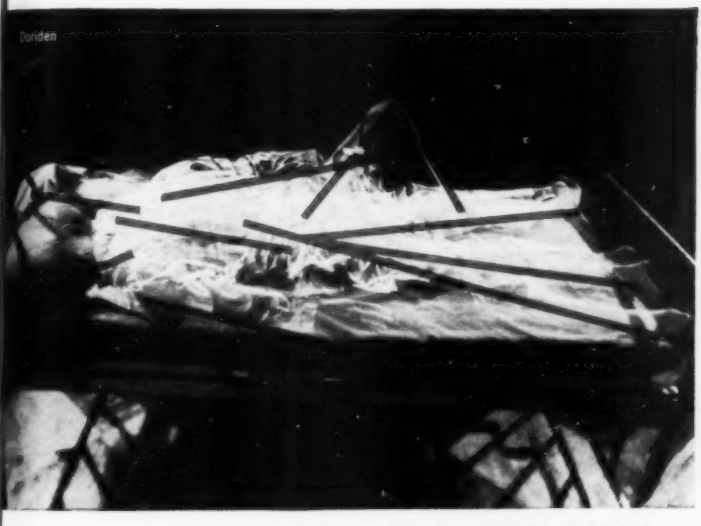
Habituation has not been reported



Twenty-eight-year-old male, restless sleeper, tense personality with occasional insomnia, was photographed at fixed intervals during the night to produce a series of exposures on same sheet of film. On placebo (above), unique "stroboscopic" picture shows him in typical fitful night of unrest.

Further clinical evidence of the sedative and hypnotic effectiveness of DORIDEN is provided by numerous clinical studies. In most cases, Doriden acts in 15 to 30 minutes, affords 4 to 8 hours of refreshing sleep . . . and come morning, the patient awakens "clear-headed."

induces sound, restful sleep



Same patient on successive night, following administration of Doriden 0.5 Gm. at bedtime, is shown in distinctly more restful repose. Total sleep was achieved in 16 minutes. Close study of activity pattern shows approximately 50 per cent reduction in overt motion and restlessness.

DORIDEN is also an excellent daytime sedative . . . calms the tense, anxious, overwrought patient.

DOSAGE: For SLEEP—0.5 Gm. at bedtime.
As a DAYTIME SEDATIVE—0.125 or 0.25 Gm. t.i.d. after meals.
TABLETS, 0.125 Gm., 0.25 Gm. (scored) and 0.5 Gm. (scored).
DORIDEN® (glutethimide CIBA)

CIBA
SUMMIT, N.J.

2/22139M

to radiologist to pathologist and back to the surgeon. The victim won't see the general practitioner again until this certified band of money-grabbing wolves has thoroughly depleted him, financially and viscerally . . .

C. H. Horst, M.D.
Butte, Mont.

'Mangled Medicine'

SIRS: The continuing vogue for Fractured French has tempted me to try my hand at Mangled Medicine. Here are a few of the definitions I've worked out:

Ansa capitis	Reply from Washington
Antecubital lesion	Citizens' committee against dice games
Autolavage	Car wash
Chloral hydrate	The boys in the choir need a drink
Deep plantar	Potato farmer
Descending colon	Typographical error
Dry vesicle	The Queen Mary in dock
Femoral annulus	Lady commentator
Intestinal grippe	Wrestling hold
Olfactory tract	1920 industrial site
Opponens pollicis	Eisenhower vs. Stevenson
Tensor tympani	Nervous drummer
Vasoconstrictor	What kind of snake?

Maybe some of your readers can suggest other definitions for this loony lexicon.

Maurice J. Teitelbaum, D.D.S.
Newark, N. J.

Collection Caution

SIRS: In a recent editorial, you expressed the view that collection stickers should be used with extreme caution, if at all. You were talking, of course, about the gum-

to help you

give your

"spastic gut"

patient

round-the-clock

relief

Prydonnal*

atropine, scopolamine, hyoscyamine, phenobarbital

Spansule*

sustained release capsules, S.K.F.

A single 'Prydonnal' Spansule capsule q12h provides 24-hour antispasmodic-antisecretory-sedative action that assures your patient distress-free days and undisturbed sleep throughout the night.

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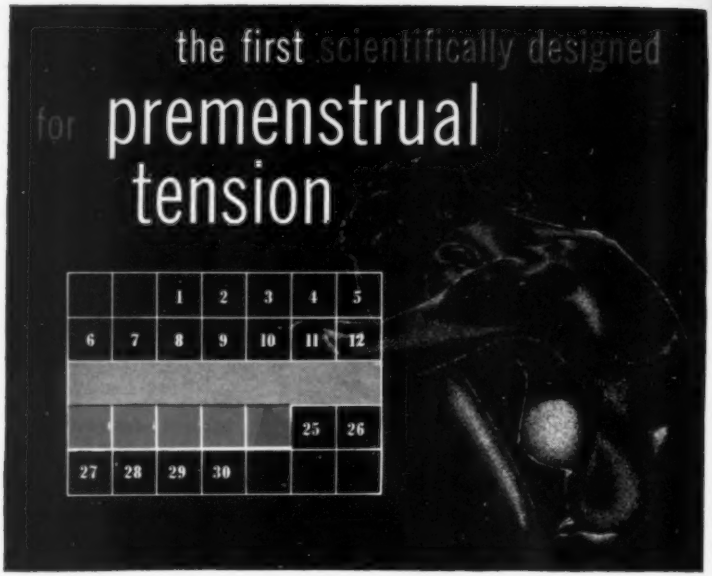
first ⧗ in sustained release oral medication

*T.M. Reg. U.S. Pat. Off. Patent Applied For.



neo Bromth®

Brand of Bromaleate, Brayten

NEO BROMTH, the first preparation developed specifically for treatment of premenstrual tension, continues to be found the most satisfactory therapeutic agent in this condition.

Bickers found that "abnormal water storage can be blocked or eliminated and clinical relief of symptoms obtained in most patients . . . "[1] with NEO BROMTH.

Greenblatt recently stated: "Clinically, we share Bickers' enthusiasm for this drug in the management of premenstrual tension, especially where there is associated edema."[2]

NEO BROMTH is non-toxic, *non-hormonal* therapy and contains no ammonium chloride. Each 80 mg. tablet contains 50 mg. of pamabrom (2-amino-2-methyl-1-propanol 8 bromo-theophyllinate) and 30 mg. of pyrilamine maleate.

Dosage: 2 tablets twice daily (morning & night) beginning at onset of symptoms —usually 5 to 7 days before menses. Discontinue at onset of flow. Supplied in bottles of 100 tablets on prescription only.

1. Bickers, W.: Southern M.J., 46:873, Sept., 1953
2. Greenblatt, R.: GP, 11:66, March, 1955

BRAYTEN PHARMACEUTICAL COMPANY Chattanooga 9, Tennessee

med reminder notices that some doctors attach to statements of slow-paying patients.

I agree with you 100 per cent. Such commercial devices are an insult to the patient.

Millard K. Mills
Professional Management
Waterloo, Iowa

Traffic Flow

SIRS: I'm not sure I agree with a couple of the recommendations in your article "26 Ways to Speed Office Traffic Flow."

First, you suggest placing the consultation room near the entrance, to localize traffic and cut the number of long trips down the hall. But it seems to me that the consultation room should be a *sanctum*, far removed from the reception area. It shouldn't be located where every patient must pass it on the way to a treatment room.

Second, some of the suggested treatment-area floor plans show examining rooms with two doors. In my observation, one door only is best for privacy and soundproofing.

Allison E. Skaggs
Professional Management
Battle Creek, Mich.

If the consultation room is in the rear, casual visitors must usually pass through the treatment area to reach it. That's why many doctors prefer a location fairly near the entrance. And while it's generally *true that one door per treatment room is preferable, this isn't* invariably *so. For example, if the doctor does minor surgery, a second door into the recovery room may be desirable.*—ED.

Licensure Barriers

SIRS: . . . In your pages recently, a Florida M.D. said: "It's harder to get a medical license than a fishing license in my state. And we intend to keep it that way."

The instinct of self-preservation is overdeveloped in this bird. He wants to abolish the Bill of Rights wherever it conflicts with his own interests. But this is still supposed to be a free country. A doctor should be able to settle wherever he wants—even in Florida!

Peter Illberg, M.D.
North Grafton, Mass.

SIRS: Hawaii, like Florida, won't reciprocate or endorse licenses from anywhere else. Furthermore, no applicant may take the exam until he's been a resident of the territory for at least one year.

Such a provision must be intended purely and simply as an obstacle to licensure. The length of residence has nothing to do with a doctor's professional or moral qualifications.

Daniel D. Lovelace, M.D.
Indianapolis, Ind.

SIRS: Article IV of the Constitu-

tion states: "Full faith and credit shall be given in each State to the public acts, records, and judicial proceedings of every other State."

Doesn't this *demand* that the states adopt universal reciprocity?

Alfred Rosskamm Ross, M.D.
New York, N. Y.

Surgical Fees

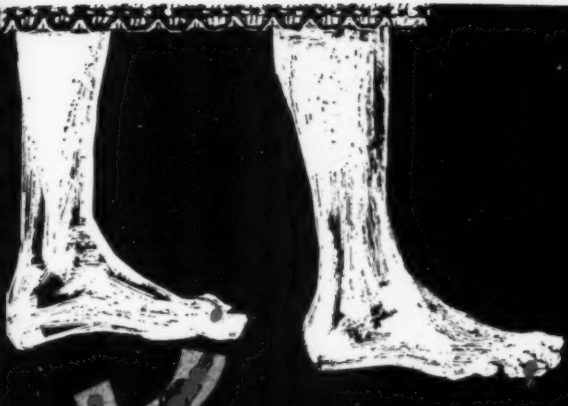
SIRS: The critics of high surgical fees apparently fail to consider the nature of most surgery: It generally offers a one-shot chance of a cure. Nonsurgical care of the same condition costs far less per visit, of course; but it may go on for years while the patient's pocketbook suffers.

The situation is roughly comparable to the problem of whether to replace an old automobile with a new one. Perhaps the old car runs fairly well but needs repeated small expenditures for repairs. Though a new automobile costs a lot of money initially, the upkeep will be minimal.

Who would insist that the price of the new car ought to be marked down because a single repair bill for the old car is so low? Nobody, of course. Then why should surgical fees be influenced by the cost of medical office visits?

Howard E. Dorton, M.D.
Lexington, Ky.

END



to suppress infection and to hasten healing of infected dermatoses

STEROSAN

(chlorquinaldol GEIGY) ointment and cream

STEROSAN—new iodine-free oxyquinoline derivative—yields exceptionally favorable results in the control of many coccal and fungal dermatoses.

In a recently reported series of 124 cases,* "clearing or marked improvement" was noted in 87.6 per cent of eczematous disorders, in 100 per cent pyogenic dermatoses, and in 72.2 per cent of dermatoses of miscellaneous type. "... The ointment appeared to be more satisfactory for dry and scaling areas, while the cream was preferable for moist and oozing lesions."

GEIGY

*Murphy, J. C.: Rocky Mountain M. J. 52:530, 1955.

STEROSAN (chlorquinaldol GEIGY) Ointment and Cream. Tubes of 30 Gm., jars of 1 lb. Prescription only.

GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, NEW YORK 13, N.Y.

more effective than one or two pints of tap water or salt solution

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Disposable Unit

"Squeeze bottle" sized for easy one hand administration . . . distinctive rubber diaphragm controls flow, prevents leakage . . . correct length of rectal tube minimizes injury hazard . . . each unit contains, per 100 c.c., 16 gm. sodium biphosphate and 6 gm. sodium phosphate . . . an enema solution of Phospho-Soda (Fleet)...gentle, prompt, thorough . . . and less irritating than soap suds enemas.

Established 1869

C. B. FLEET CO., INC., LYNCHBURG, VIRGINIA

Makers of Phospho®Soda (Fleet), a modern laxative of choice.

"Taste Appeal" for the Low-Fat, Low-Cholesterol Diet

Palatability is the key to planning this special diet. And these flavor tips will help you keep in the "taste appeal" in your patient's diet.

These are for flavor—

Cranberry and tomato sauce pinch-hit for gravy. Fruit juices are to baste with as well as to drink. And herbs and spices lend a fine aroma to meats and vegetables.

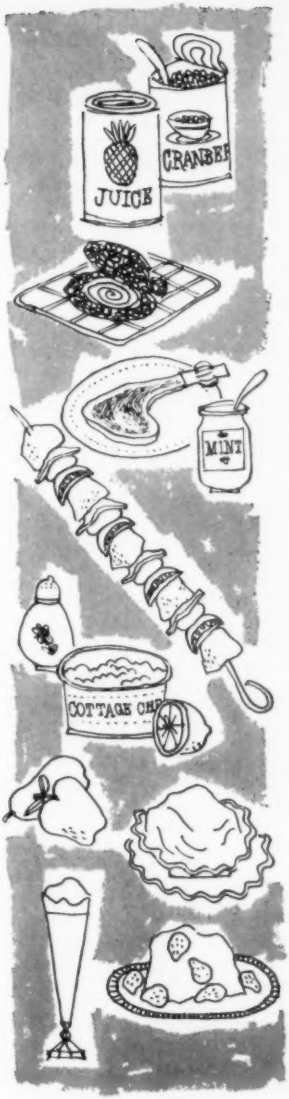
Here's where they go—

Meat loaf can sport a gay cap of whole-cranberry sauce, while "surprise" hamburgers hide a slice of onion between two thin patties. Your patient can glaze lamb chops with mint jelly. And kabobs add something different.

Most vegetables can be dressed simply to taste with lemon juice or an herb vinegar. On green salads, cottage cheese thinned with lemon juice, sparked with paprika, makes the dressing. And on fruits, try lemon juice, honey and chopped mint.

For dessert, angel cake goes nicely under fruits—skim milk powder makes the "whipped cream." Snow pudding is a simple dessert—fresh fruit, even more so.

These "diet do's"—plus an occasional glass of beer*, if you permit—will help keep your patient happy within the limits you set for his diet.



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Beer—America's Beverage of Moderation

*Fat—0; Calories 104/8 oz. glass (Average of American Beers)

If you'd like reprints for your patients, please write United States Brewers Foundation, 535 Fifth Ave., New York 17

Evaporated or Powdered, Meyenberg (the original) Goat Milk is a natural milk likely to give prompt control of cow's milk allergy. It provides a soft, readily-digestible curd . . . will not cause the diarrhea often associated with milk substitutes.

Meyenberg Goat Milk is nutritionally equivalent to evaporated cow's milk in fat, protein and carbohydrates.

Specify Meyenberg Goat Milk First Evaporated in 14-ounce enamel-lined, vacuum-packed cans. Powdered in 14-ounce, vacuum-packed cans.

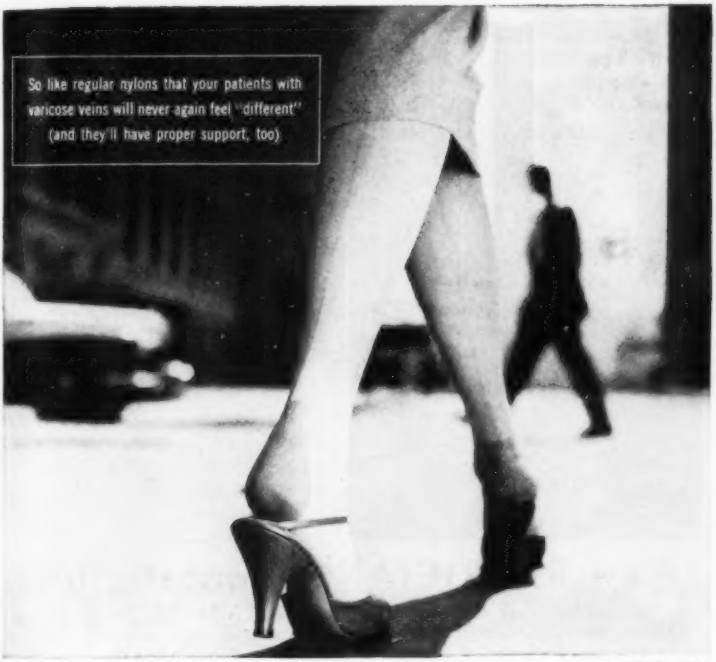
For further information write:

JACKSON-MITCHELL Pharmaceuticals, Inc. Culver City, Calif.

Serving the Medical Profession Since 1934

Now from Bauer & Black

the first 51 gauge elastic stockings



Here at last are elastic stockings your patients will take to cheerfully. 51 gauge, made with threads twice as thin and twice as light as former kinds. So sheer they make "overhose" a thing of the past. Full-fashioned like regular nylons.

Yet, sheer as they are, Bauer & Black's 51 Gauge Elastic Stockings provide proper remedial support. Pressure decreases gradually from the ankle up, gently speeding venous flow.

New full-footed style

These full-footed stockings can be worn all day, every place your patient may go. Heel and toe are non-elastic, made with Helanca® stretch nylon to prevent cramping or binding.

To be *sure* of patient cooperation, doctor, aren't these the elastic stockings to prescribe?

Of course, you and your patients can still choose from the complete Bauer & Black line: nylon or cotton . . . open toe or closed toe . . . knee length, above knee or extra long . . . variety of prices.

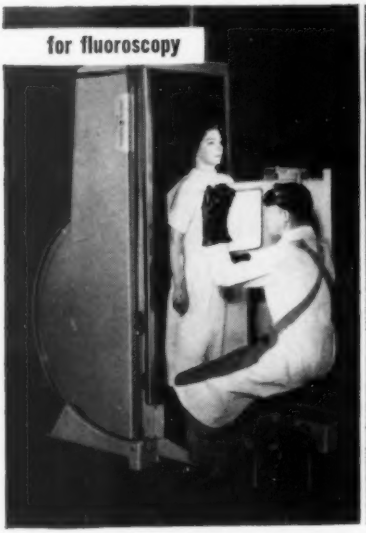
51 Gauge Elastic Stockings

BAUER & BLACK

Division of The Kendall Company
309 W. Jackson Blvd., Chicago 6, Ill.

Now, for only $4950* G. E. brings you complete 200-ma x-ray facilities

*f.o.b. Milwaukee, U.S.A.



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— the low-cost x-ray unit with major features you've always wanted. You get 81-inch angulating table • independent tube stand with choice of floor-to-ceiling or platform mounting • 200 ma-100 kvp, full-wave transformer and control • double-focus, rotating-anode tube. But that's not all.

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The new PATRICIAN features a counterbalanced fluoroscopic unit with full screening coverage. Even the new automatic reciprocating Bucky is counterbalanced — self-retaining in all table positions.

Contact your General Electric x-ray representative for details or demonstration, and be sure to have him explain the G-E Maxiservice® *rental* plan. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for Pub. C-61.

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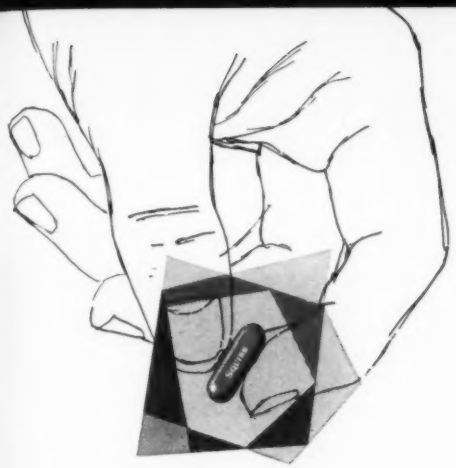


just 1 tablet daily

helps meet the increased nutritional requirements of pregnancy

ENGRAN

SQUIBB VITAMIN-MINERAL SUPPLEMENT

new formula

new small size capsule-shaped tablet

Each Engran Tablet supplies:

Vitamin A (synthetic)	5,000 U.S.P. Units	Calcium, elemental (as calcium carbonate)	150 mg.
Vitamin D	500 U.S.P. Units	Iron, elemental (as ferrous sulfate exsiccated)	10 mg.
Thiamine mononitrate	3 mg.	Iodine (as potassium iodide)	0.15 mg.
Riboflavin	3 mg.	Potassium (as the sulfate)	5 mg.
Pyridoxine HCl	2 mg.	Cobalt (as the sulfate)	0.1 mg.
Vitamin B_{12} activity concentrate	2 mcgm.	Copper (as the sulfate)	1 mg.
Folic acid	0.25 mg.	Magnesium (as the oxide)	6 mg.
Niacinamide	20 mg.	Manganese (as the sulfate)	1 mg.
Calcium pantothenate	5 mg.	Zinc (as the sulfate)	1.5 mg.
Ascorbic acid	75 mg.		

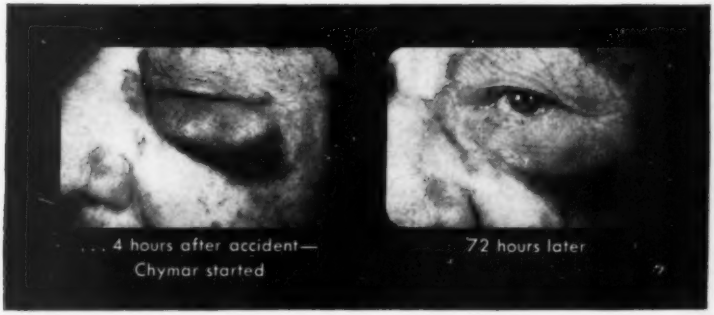
Supplied in bottles of 100 and 1000 capsule-shaped tablets

SQUIBB

the new injectable enzyme

CHYMAR

relieves inflammation through systemic action



Chymar reduces edema...hastens absorption...
reduces inflammation . . . restores circulation . . .
stops further tissue necrosis . . . promotes healing.

Chymar is a suspension of chymotrypsin, a proteolytic enzyme, in sesame oil for intramuscular injection. Each 1 cc. supplies 5000 units of proteolytic activity. In 5 cc. vials.

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An Alterative FOR PSORIASIS

Since the dawn of dermatology, mercury s been the standard local treatment for oriasis. It still occupies first position. Goodman and Gilman* in 1955 say that mmoniated mercury is used for the scal- in psoriasis, and also that the mercury in low concentration exerts its action r long periods of time.

As compared with ammoniated mercury tment 5%, only 1/9th as much mercury needed when combined chemically with ps as in RIASOL. This is because the onaceous vehicle of RIASOL, unlike linary ointments, penetrates the super- al layers of the epidermis. Hence there greater therapeutic effect with a mini- m of irritation and toxicity.

RIASOL has been used since 1940 and oday one of the most widely prescribed all drugs in the local treatment of oriasis.

RIASOL contains 0.45% mercury, chem- lly combined with soaps, 0.5% phenol d 0.75% cresol in a washable, non-stain- , odorless vehicle.

Apply daily after a mild soap bath and rough drying. A thin invisible, econom- l film suffices. No bandages required. er one week, adjust to patient's progress. Ethically promoted RIASOL is supplied 4 and 8 fld. oz. bottles at pharmacies or ect.

odman, L. S. & Gilman, A., Pharmacological Basis Therapeutics, 2nd ed., 1955, pp. 1103-04.

Test RIASOL Yourself

May we send you professional literature and generous clinical package of RIASOL. No obligation. Write

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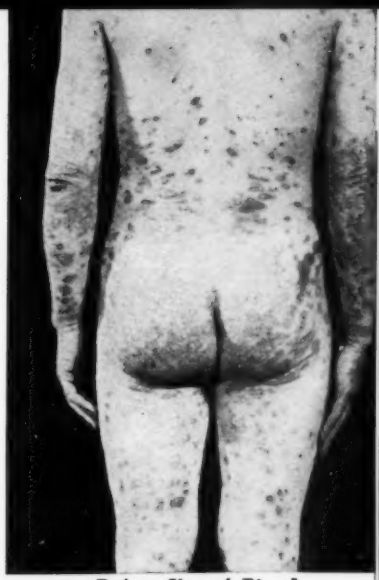
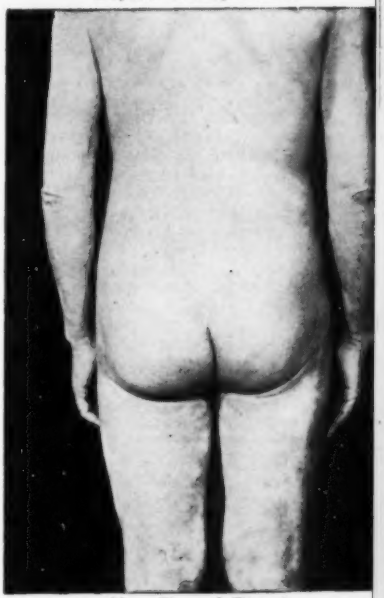


Before Use of Riasol



After Use of Riasol

RIASOL FOR PSORIASIS

XUM

safe and sure laxation

Agoral relieves constipation gently, without strain. A dose taken at bedtime almost always produces results the next morning. A patient taking Agoral can follow a normal, daily routine because Agoral does not provoke the sudden urge induced by strong laxatives.

Excellent in pregnancy. Agoral's action is gentle and positive, an important consideration especially during the last trimester of pregnancy. Agoral is also well suited in all other cases of acute and chronic constipation, where straining or purges are to be avoided: in children, postoperatively, and in bedridden and older people.

Agoral mixes readily and uniformly with the intestinal contents during its passage through the tract. It aids in retention of fluid in the fecal column, affords lubrication and provides mild peristaltic stimulation. Agoral causes no sudden, uncomfortable griping, distention or stomach distress. Used for prompt relief, it is not habit forming and may be prescribed for protracted periods.

Dosage: At bedtime, ½ to 1 tablespoonful. Contraindications: symptoms of appendicitis; idiosyncrasy to phenolphthalein.

Supplied: Bottles of 6, 10 and 16 fl. oz.; and as Agoral Plain (without phenolphthalein), bottles of 6 and 16 fl. oz.

Agoral® *the laxative to meet all needs*

mineral oil emulsion with phenolphthalein

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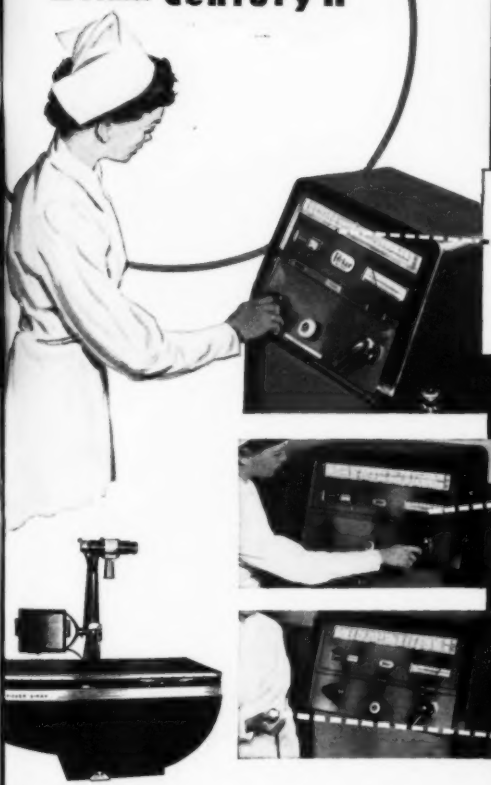
new
way in x-ray
is *dial-the-part* automation
in Picker Century II



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here's all you do...

dial
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on the big selector scale (inset here is a typical body-part "station").

set
its thickness
point the needle to the measured thickness of that part of the patient you're x-raying

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the radiograph
that's all there is to it. "Dial-the-part" automation takes it easy, gets it right every time.

anatomatic Century II
fluoroscopic-radiographic x-ray unit

Ask your local Picker representative about the new "ANATOMATIC"; let him show you how it works, tell you how modest its cost, what a boon for you it may well prove to be.

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Adhesive Bandages
with **SUPER-STICK**

1. Superior *stick*—provides better protection!
2. Better elasticity—conforms comfortably!
3. In handy, long-lasting dispensing box!
4. A COMPLETE LINE of strips... patches... ovals... and professional sizes!

If you prefer *elastic* adhesive bandages, use the best.

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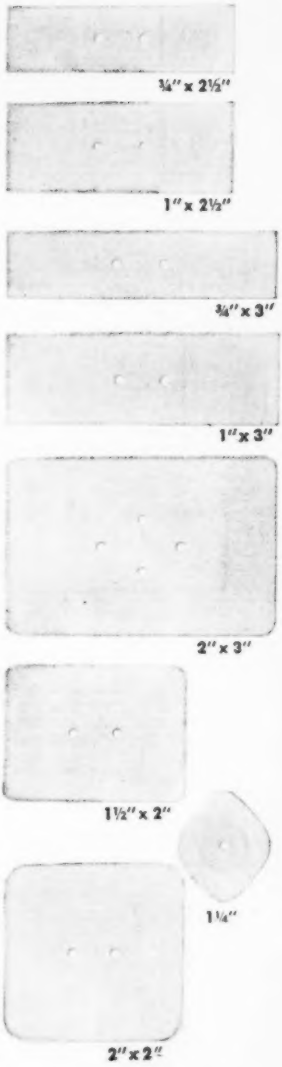

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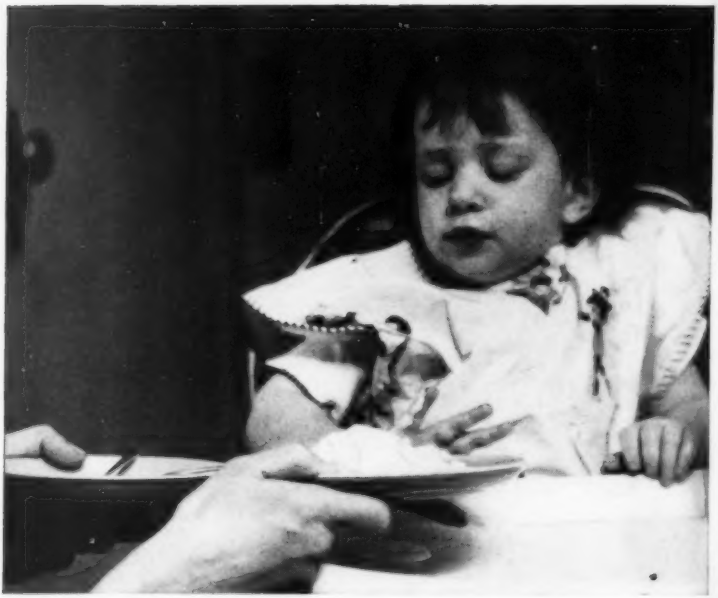

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LACTOFORT

. . . with growth promoting L-*lysine*
. . . and all the essential vitamins
. . . plus iron and calcium . . .

Improves protein utilization—
stimulates appetite—
promotes weight gain

Supplied: In 46 Gm. bottles with special Lactofort measuring spoon enclosed.

2 measures (2.3 Gm.) of Lactofort supply:

L-Lysine Monohydrochloride	660 mg.*
Vitamin A Acetate	3,750 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	0.75 mg.
Riboflavin	1.25 mg.
Niacinamide	7.5 mg.
Vitamin B_{12}	2.5 mcg.
Folic Acid	0.25 mg.
Ascorbic Acid (from Sodium Ascorbate)	75 mg.
Pyridoxine Hydrochloride	0.75 mg.
Calcium Pantothenate	7.5 mg.
Iron (elemental) (from Iron Ammonium Citrate Green)	7.5 mg.
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*Equivalent to 500 mg. L-lysine

a dry stable powder • odorless • tasteless • readily soluble

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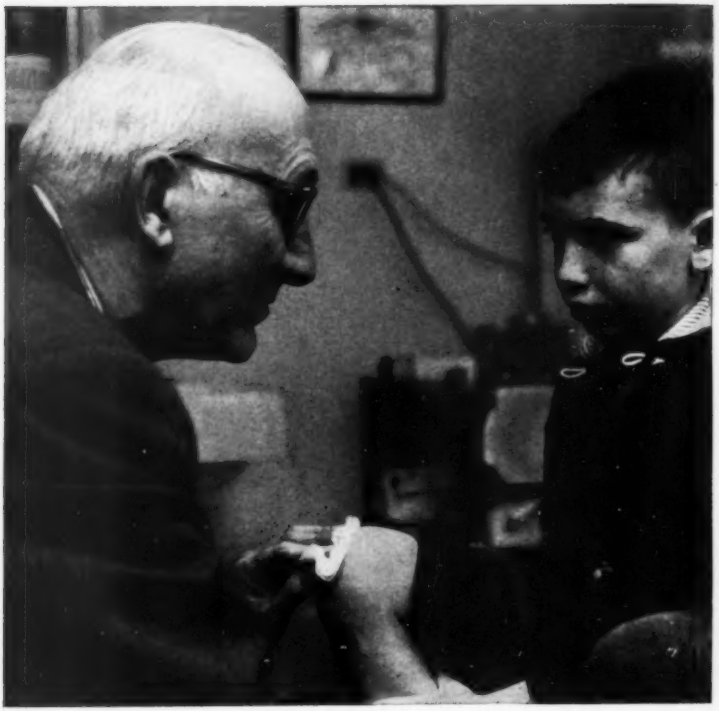

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soothing topical anesthetic

OINTMENT, 1%, in 1-ounce tubes with "peel-off" labels and rectal applicator; 1-pound jars for office use.

CREAM, 0.5%, in 1¼-ounce tubes.

OPHTHALMIC OINTMENT, 0.5%, in ophthalmic-tip tubes of 4.0 Gm. each.

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- **to control topical pain in minor office procedures and in the removal of surgical dressings.**
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Views

Social Security Stand

"If you ask a dozen professional men how they feel about Social Security, you'll get twelve different answers. These fellows don't know *what* they want." So spoke a member of the House Ways and Means Committee back in 1954.

Among those who didn't then know what professional men wanted were their own professional organizations—the American Bar Association, the American Dental Association, and the A.M.A. All three told Congress in 1954 that their members opposed Social Security. But they didn't really have the facts.

Since then the facts have started to come in. And they've led the three professional groups in different directions:

The Bar Association now favors *compulsory* inclusion of lawyers under Social Security. The Dental Association wants Congress to make *optional* coverage available to dentists. The A.M.A. still prefers *no* coverage for physicians—though it has indicated it wouldn't actually oppose optional coverage, if offered.

This cleavage is a good thing in at least one respect: It shows the extent to which professional groups are making their policies an accurate reflection of members' thinking.

Take the lawyers, for example. Two years ago the Bar Association polled its members—and the vote went for voluntary inclusion.

But that vote didn't settle anything. As this magazine has pointed out, Congress is extremely unlikely to offer the professions optional Social Security coverage. The real choice is compulsory coverage or none.

Realizing this, the lawyers took a second poll. This time they voted

Erythrocin in the treatment of pharyngitis*

9/12/55 **DISCHARGE SUMMARY**

Patient, male, age 40, entered hospital with history of sore throat starting 48 hours previous to admission.

Physical examination revealed throat to be infected and red with severe hyperplasia of lymphoid tissues. Throat culture revealed Group A beta hemolytic streptococcus.

Patient was started on 200 mg. of Erythrocin four times a day for three days. Subjective and objective improvement within 48 hours. No side effects. Three cultures taken subsequently did not show Group A beta hemolytic streptococcus.

Final Diagnosis: acute streptococcal pharyngitis.

Result: rapid and complete recovery with Erythrocin.

*Communication to Abbott Laboratories

specific against coccic infections

Specific—because you can actually pinpoint the therapy for coccic infections. That's because you know most bacterial respiratory infections are caused by staph-, strep- and pneumococci. And these are the very organisms most sensitive to ERYTHROCIN—even when they resist penicillin and other antibiotics.

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Erythrocin®

(Erythromycin Stearate, Abbott)

STEARATE

with little risk of side effects

Low toxicity—because ERYTHROCIN (in contrast to many other antibiotics) rarely alters intestinal flora. Thus, patients seldom get gastroenteral side effects. Or less of vitamin synthesis in the intestine. No allergic reactions, either. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), bottles of 25 and 100. Abbott

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Erythrocin®

(Erythromycin Stearate, Abbott)

STEARATE

®Filmtab—film-sealed tablets; pat. applied for

605109

to seek "compulsory coverage for self-employed lawyers . . . if voluntary coverage is not obtainable." And that's their position today.

The dentists, too, have moved from complete opposition to the middle ground of seeking voluntary inclusion. But they haven't yet faced the real decision between compulsory coverage and none.

Where do physicians stand in this crystallizing process? Last December the A.M.A. voted to hold its first profession-wide poll on Social Security. That poll is now in progress. The voting is being managed by state medical societies, as in Ohio and Vermont; or by county societies, as in New York and Massachusetts. Each association is free to pick what its members shall vote *on*. Thus:

Some physicians are choosing among voluntary Social Security, compulsory, or none. Others are considering these three plus a Jenkins-Keogh-type retirement plan. In only two areas, at this writing, have physicians decided simply whether they want to join the Social Security system or to stay out. (These areas are Northern New York, where 213 doctors want compulsory coverage and 380 want none; and Maine, where early returns show 181 doctors favoring compulsory coverage and 262 opposing it.) [MORE▶

invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes . . . Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours . . . Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Tedral provides:

Theophylline	2 gr.
Ephedrine HCl	⅜ gr.
Phenobarbital	⅛ gr.

in boxes of 24, 120 and 1000 tablets

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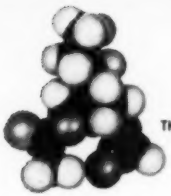


THE MILTOWN MOLECULE

'the tranquilizer with NO KNOWN CONTRA-INDICATIONS

ideal for prolonged therapy

- Effective in anxiety, tension and muscle spasm
- Well tolerated—not habit forming—essentially non-toxic
- Does not produce depression
- Orally effective within 30 minutes for a period of 6 hours
- Supplied in 400 mg. tablets. Usual dose: 1 or 2 tablets—3 times a day

Miltown®

the original meprobamate—2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U. S. Patent 2,724,720

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N.J.

Literature and Samples Available On Request

The bar has crystallized its thinking on Social Security. Dentistry is well on the way. Unless medicine catches up, and quickly, it will have lost its best chance for effective action based on what its practitioners want.

Fees and Honorariums

Dr. Elmer Hess confessed recently that he disliked the word "fee." Said the outgoing President of the A.M.A.: "I prefer the word *honorarium.*"

We can't help observing that Dr. Hess's comment runs counter to his usual plain-talking self. *Fee* is a word that's been in the language for at least eight centuries, and its meaning has always been clear: A fee is a payment for service rendered.

Honorarium is a much more slippery customer. The word itself is a recent import from Latin, and its meaning can be a bit fuzzy. An honorarium, say the dictionaries, is a token payment in return for gratuitous services. It isn't the straightforward charge you make for services rendered in expectation of payment.

In our opinion, *honorariums* are appropriate only for the doctor who wants people to look on him as an *eleemosynary institution*, not interested in *emolument*. That

Areas of Clinical Study / One of a series

ANEMIA OF PREGNANCY

Maintenance of normal blood values during pregnancy is a factor in the welfare of the mother at delivery and in preventing anemia in the infant. Improvement in the patient's vitality and emotional stability during gestation can also be achieved.

RONCOVITE, *the original, clinically proved cobalt-iron product, has introduced a wholly new concept in the prevention and treatment of anemia. It is based on the unique hemopoietic stimulation produced only by cobalt. The application of this new concept routinely in pregnancy practically insures against the development of iron-deficiency; its use has also led to marked, dramatic advances in the successful treatment of many of the anemias.*

In a recent clinical study of anemia in pregnancy, Holly[1] *reports:*

—about 80 per cent of normal patients manifest significant decreases in hematologic values during pregnancy.

—conversely, 90 per cent of pregnant women maintained hemoglobin levels of 12 Gm. per cent or over when given Roncovite (iron-cobalt therapy). No other medication tested was so successful.

—in fact, 63 per cent of these Roncovite treated patients delivered with the unusually satisfactory level of 13 Gm. per cent hemoglobin.

—Roncovite (iron-cobalt therapy) was proven to be the most effective hematinic. In fact, 57 of 58 patients (98.2%) maintained or improved their hemoglobin values.

RONCOVITE IS A SAFE DRUG.

in pregnancy—

"No toxic manifestations associated with its use have been observed."[1]

In prematures—

"None of them showed harmful effects despite the large doses..."[2]

In pharmacology—

"Histopathologic studies of rats that received cobaltous chloride ...revealed no significant degenerative changes in parenchymal organs as evidence of toxicity."[3]

SUPPLIED:

RONCOVITE TABLETS

Each enteric coated, red tablet contains:

Cobalt chloride..... 15 mg.
Ferrous sulfate exsiccated..... 0.2 Gm.

RONCOVITE-OB

Each enteric coated, red capsule-shaped tablet contains:

Cobalt chloride..... 15 mg.
Ferrous sulfate exsiccated..... 0.2 Gm.
Calcium lactate..... 0.9 Gm.
Vitamin D..... 250 units

RONCOVITE DROPS

Each 0.6 cc. (10 drops) provides:

Cobalt chloride (Cobalt 9.9 mg.)..... 40 mg.
Ferrous sulfate..... 75 mg.

DOSAGE:

One tablet after each meal and at bedtime. Children 1 year or over, 0.6 cc. (10 drops); infants less than 1 year, 0.3 cc. (5 drops) once daily diluted with water, milk, fruit or vegetable juice.

1. Holly, R. G.: Anemia in Pregnancy, Obstet. & Gynecol. *5:*562 (April) 1955.
2. Quilligan, J. J., Jr.: Texas State J. Med. *50:* 294 (May) 1954.
3. Hopps, H. C.; Stanley, A. J., and Shideler, A. M.: Polycythemia Induced by Cobalt, Amer. J. Clinical Path. *24:* (Dec.) 1954.

Bibliography of 192 references available on request.

RONCOVITE

The original, clinically proved cobalt-iron product

LLOYD BROTHERS, INC.

Cincinnati, Ohio

In the Service of Medicine Since 1870

doesn't sound like Elmer Hess—nor like any other down-to-earth doctor we know.

Joint Confusion

An article elsewhere in this issue makes it vividly clear that a good many doctors have been confused by the requirements of the Joint Commission on Accreditation of Hospitals.

Why? One reason is the conflicting statements about those requirements put out by the Joint Commission itself.

Take, for example, the question of staff meetings. Is it a flat rule that all hospitals must hold regular meetings of the entire active staff? Or isn't it?

Listen to the Joint Commission itself on this subject:

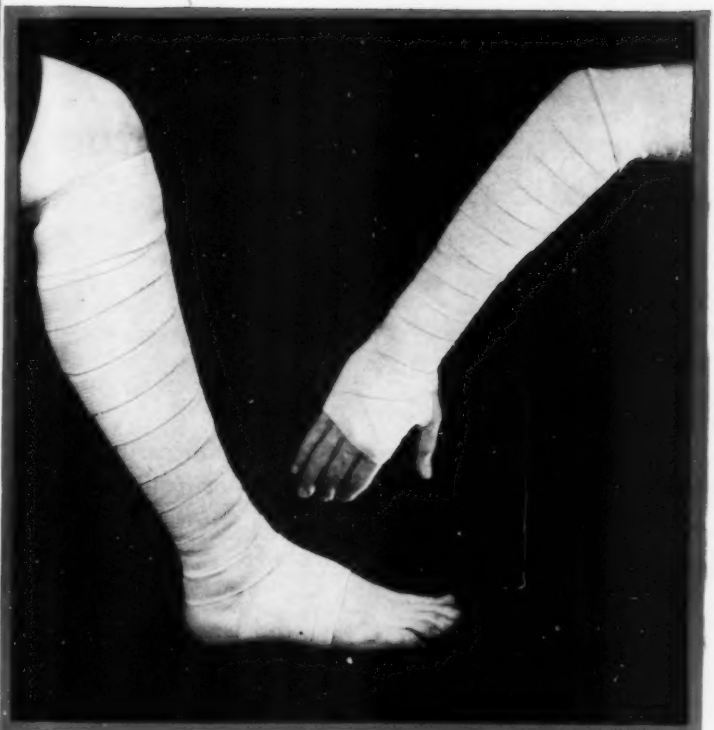
Its Bulletin No. 9 dated August, 1955, specifies three approved types of hospital staff meetings:

1. "Monthly meetings of the entire active medical staff";

2. "Monthly departmental meetings and quarterly meetings of the entire active medical staff";

3. Monthly meetings of certain key committees, "plus quarterly meetings of the entire active medical staff."

"Experience has shown," adds Bulletin No. 9, "that one of these three patterns . . . will fit any hos-



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elasticity for compression • body for support

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IN WOMEN,

the preferred broad spectrum antibiotic preparation is

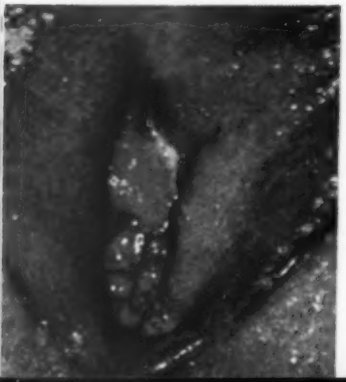
MYSTECLIN

STECLIN-MYCOSTATIN (SQUIBB TETRACYCLINE-NYSTATIN)

Usual broad spectrum antibiotic therapy may be followed by vaginal moniliasis. Mysteclin supplies well tolerated broad spectrum therapy without subsequent vaginal moniliasis.*

*Stone, M. L., and Mersheimer, W. L.: "Comparison of side effects of tetracycline and tetracycline combined with nystatin." Antibiotics Annual 1955-56, New York, Medical Encyclopedia Inc., 1956, p. 862.

Vaginal moniliasis following antibiotic therapy



Oral antibiotic therapy may cause an overgrowth of monilia in the vagina, producing vaginal moniliasis with vulvar pruritus and vaginal discharge. All women are susceptible, but this complication is especially frequent in women who are pregnant or diabetic. In many cases, the woman fails to inform the physician through embarrassment or failure to relate the condition to preceding antibiotic therapy.

SQUIBB

vaginal moniliasis: an increasingly common complication of antibiotic therapy

"... wide use of penicillin and broad spectrum antibiotics, with resultant disturbance of vaginal bacteriology has increased markedly the incidence of yeast and fungus infections of the vagina. . . . Before advent of the wonder drugs, relationship of trichomonas to monilia was roughly four to one in the usual office practice. Within the past eight years the ratio has been reversed with three monilia problems to one of trichomonas."

Lee, A. F, and Keifer, W. S.: Northwest Med. 53:1227 (Dec.) 1954.

"Vaginal moniliasis ... is quite common and the incidence may well have been increased following the extensive use of the broad-spectrum drugs or prolonged oral use of penicillin."

Welch, H.: Editorial, Antibiotic Med. 2:79 (Feb.) 1956.

MYSTECLIN

the only broad spectrum antibiotic preparation that:

1: provides the antibacterial activity of tetracycline and

2:protects the patient against monilial superinfection

Mysteclin Capsules contain 250 mg. Steclin (Squibb Tetracycline) Hydrochloride, a well tolerated broad spectrum antibiotic, and 250,000 units Mycostatin (Squibb Nystatin), the first well tolerated antibiotic active against fungi. Minimum adult dosage: 1 capsule q.i.d. Supply: Bottles of 16 and 100.

also *available:* MYSTECLIN Half Strength Capsules (125 mg. Steclin Hydrochloride and 125,000 units Mycostatin): Bottles of 16 and 100.

A PARTIAL LIST OF INDICATIONS FOR MYSTECLIN

When caused by tetracycline-susceptible organisms, the following conditions are among those which may be expected to respond to Mysteclin:

Abscess	Metritis
Bronchiectasis	Osteomyelitis
Bronchitis	Otitis Media
Bronchopneumonia	Peritonitis
Burns, Infected	Pertussis
Cellulitis	Pharyngitis
Cervicitis	Pneumonia
Chancroid	Psittacosis
Colitis	Pyelonephritis
Cystitis	Q Fever
Diarrheas, Infectious	Rocky Mountain Spotted Fever
Dysentery, Amebic	Salpingitis
Dysentery, Bacillary	Scarlet Fever
Empyema	Scrub Typhus
Endocarditis, Bacterial	Sepsis, Puerperal
Epididymitis	Septic Sore Throat
Furunculosis	Septicemia
Gastroenteritis	Sinusitis
Gonorrhea	Skin Graft Infections
Granuloma Inguinale	Surgical Prophylaxis
Klebsiella Pneumonia	Tonsillitis
Laryngitis	Tracheobronchitis
Lymphadenitis	Tularemia
Lymphangitis	Typhus
Lymphogranuloma Venereum	Urethritis
Mastoiditis	Vesiculitis
Meningitis	Wounds, Infected

It is impossible to predict with certainty in which patients clinical moniliasis may develop as a result of broad spectrum antibiotic therapy.

However, the added protection afforded by Mysteclin against monilial superinfection is *especially* important when antibiotic therapy must be prescribed in high dosage or for prolonged periods.

It is also particularly important in women; in debilitated, elderly, or diabetic patients; in infants (particularly prematures); in patients for whom concomitant cortisone or related steroid therapy is prescribed; and in individuals who have developed a monilial complication on previous broad spectrum therapy.

pital seeking accreditation, whether it be small or large, rural or urban, affiliated with a medical school or not." *In short, there are no exceptions to the full-staff-meeting rule.*

Now listen to what the Commission says in its "Standards for Hospital Accreditation," dated January, 1956:

"In very large hospitals where attendance requirements are obviously met by departmental meetings and where physical facilities are not available for large audiences, the Commission may accept departmental meetings in lieu of meetings of the entire medical staff." *In short, there* are *exceptions to the full-staff-meeting rule.*

Which publication of the Joint Commission d'you read?

Preventive Medicine Pays

Most doctors agree that an annual check-up for everybody in the country would be good medicine. Even so, they seem hesitant about pushing the idea.

"Sure, I'd like every patient on my list to come in once a year," says one man we know. "But there's no way to *make* patients come."

The truth is, it doesn't take much pushing. People are a lot readier for preventive medicine than most doctors seem to have realized. Evidence is piling up on several sides:

Elsewhere in this issue, we describe the remarkable practice of Dr. Robert Marin of New Jersey. Dr. Marin specializes in check-ups, and he won't accept a patient who doesn't agree to have annual examinations. Do patients resent this? On the contrary, they seem to welcome it. Dr. Marin has more patients than he can handle; his collection ratio approaches 100 per cent; and at least one patient on his list travels 1,000 miles to his office every year especially to get the check-up.

Other evidence comes from a new study made under the auspices of the Health Information Foundation. Researchers interviewed thirty "low-income" (average: $3,900) families and thirty "high-income" (average: $6,800) families in Yonkers, N.Y., about their health practices. Forty per cent in both groups were found to be devotees of regular medical check-ups.

Perhaps typical of the 40 per cent was one family of father, mother, and child. Its yearly income: $4,900. Its stated motto: "Pay the doctor to keep you well." The mother in this family reported: "Our dentist sends us reminder notices, and so does our doctor. We all go. And our family health bill last year was just $90."

This family is a walking advertisement for preventive medicine. It enjoys good health and low medical bills. And reminder notices are apparently the key.

[MORE ▶

BON VOYAGE BEGINS WITH BONAMINE*

BRAND OF MECLIZINE HYDROCHLORIDE

longest-acting motion-sickness remedy[1] effective in low dosage . . . controls motion sensitivity symptoms in minutes . . . one dose usually prevents motion sickness for 24 hours.

in recommended dosage Bonamine is notably free from side reactions . . . supplied as: BONAMINE TABLETS, scored, tasteless, 25 mg. . . . BONAMINE CHEWING TABLETS, pleasantly mint flavored, 25 mg.

*Trademark

1. Report of Study by Army, Navy, Air Force Motion Sickness Team: J.A.M.A. 160:755 (March 3) 1956.

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N.Y.

Most people hesitate to seek out busy doctors "just for a check-up." But when, like Dr. Marin and the men in Yonkers, physicians *encourage* such examinations, the response is likely to be overwhelming. And that's good for everyone concerned.

Islands for Sale

Want to get away from it all this summer? Perhaps you'd like to think about buying or renting an island.

There are something like a million habitable islands for sale in this country. Not more than a few hundred of them have telephones. Almost none have parking problems. Prices begin around $400.

You can do even better in Canada. The Province of Ontario alone has some 2 million lakes, most of them islanded. The Ontario government will rent you one of the islands for $10 per acre per year.

Or try Alaska. The U.S. Forest Service will let you have a fine, big island all summer for $25. A complete absence of night calls is guaranteed. In fact, there won't even be much night, that far north.

It all adds up to *change of pace*. And after some fifty weeks' concentration on people with problems, that's what many an M.D. needs most. END

Now you can add her stylish fancy to your prescription facts.

Soft plastic purse.
3 oz. tube of Lanteen jelly.
New Easy-clean jelly applicator.
Lanteen flat spring diaphragm of prescribed size.
Universal inserter.

The new Lanteen Exquiset reflects the best of milady's taste—it's both stylish and discreet. Your patient will appreciate your prescription for the Lanteen Exquiset. You will have prescribed an effective contraceptive technique, and also taken account of her feminine fancy. Another design by Lanteen for better patient-cooperation.

new! LANTEEN® *Exquiset*®

Physician's prescription package.

Lanteen jelly and flat-spring diaphragm sets are distributed by George A. Breon & Company, 1450 Broadway, New York 18, N. Y. (In Canada: E. & A. Martin Research Ltd., 20 Ripley Ave., Toronto, Canada.) Manufactured by Esta Medical Laboratories, Inc., Chicago 38, Ill. ®Trademark of George A. Breon & Company.

'Let G.P.s Show What They Can Do'

Here's an exclusive sum-up of the general practitioner's recent gains, by the first G.P. to head the A.M.A. since 1874

By Dwight H. Murray, M.D.

Not long after I was named President-elect of the A.M.A., a G.P. colleague slapped me on the back and remarked: "Well, Murph, it's going to be nice having one of us in the saddle. With you there, maybe the A.M.A. will start paying us G.P.s the heed we deserve."

Secretary of Defense Charles Wilson once made the mistake of maintaining that what was good for General Motors was good for the country. I could make the same mistake by insisting that what's good for general practice is good for the medical profession.

But I won't. Believe me, I'm just as proud of being a G.P. as I am of being an A.M.A. officer—but I'll always wear my caps separately. Never at the same time. This

---

THE AUTHOR *takes office this month as the one hundred and tenth president of the American Medical Association.*

declaration will come as a disappointment to the friend I mentioned above. It may also disappoint other G.P.s who've perhaps hoped I'd charge into office on a white steed, prepared to wipe out all their alleged grievances in one fell swoop. But I want to make my position plain, because I believe it's time that many of my generalist colleagues dropped their persecution complex.

I firmly believe that the G.P. of today has far more blessings to count than he realizes.

Stone-Cold Dead

Just nine short years ago, the collective "specialty" of general practice seemed stone-cold dead. There was no pride in the G.P.'s voice or manner when he called himself a family physician. The average G.P. was made to feel inferior by the welter of erudite specialists around him. He sensed that the time was near when cardiologists, neurologists, psychiatrists, hematologists, otologists, urologists, and so on ad infinitum would have the body thoroughly compartmentalized. Nothing would be left for him to treat, he feared, but measles and mumps.

In 1947, though, something happened that snatched the corpse from the embalming table and breathed new life into it: The American Academy of General Practice was formed.

60 Percenters

The Academy has given the G.P. a much-needed feeling of "belonging." It has brought paternal guidance to a once-disorganized group—which nevertheless comprised 60 per cent of the A.M.A.'s total membership.

Today the A.A.G.P. is a hundred times larger than it was at its inception. Aside from fighting (and usually winning) the G.P.'s battles, the organization has bestowed a number of blessings upon its membership. Among them: a monthly journal that, in my opinion, is far superior to any of its specialty companions; and an ambitious self-improvement program. But the thing that proved its worth to many G.P.s was the Academy's hard drive for wider hospital privileges, which came to a successful climax at last winter's Boston meeting of the A.M.A.

As one medical leader has said since then: "At long last, American medicine has tossed into the sea any and all rules by which G.P.s are relegated to an inferior

position in hospital staff organization."

The promises made in Boston mean far more to the G.P. than any lip service he may have had in the past. He's now virtually guaranteed that his practice won't be hindered by hospital rules and regulations that "exclude or arbitrarily restrict hospital privileges for generalists as a class, regardless of their individual competence."

The Doctor's Limits

However, as one G.P. has written: "This does not mean that every G.P. shall be privileged to do anything in the hospital of which he feels himself capable. It does mean that he shall be given the opportunity to demonstrate his abilities, as developed by training and experience, to his colleagues on the staff; and that, in the granting of privileges, he shall not be penalized merely because he is a generalist.

"This does not mean that every G.P. is guaranteed an appointment to the active staff of every hospital. It does mean that he must be afforded access to the use of the hospital facilities in his community."

I second those words. I've always contended that a doctor—whether specialist or generalist—must prove his ability before he's permitted to take care of seriously ill people in hospitals. Just because a man is a board diplomate, he isn't necessarily capable. Many a specialist has crammed for a board examination and then promptly forgotten what he memorized by rote.

My contention is that *all* doctors should prove their ability to the satisfaction of their colleagues before being granted full hospital privileges. If the A.M.A. operated under a dictatorship (and I'm glad it doesn't), here's the ultimatum I would pass down:

Probation Period

Every new man in a community who wants an appointment to a hospital staff must be given the opportunity to prove his ability.

Suppose, for instance, that he wants unlimited operating privileges. Well, then, he's given that right at first—but only under the direct supervision of a senior surgeon. He's on probation, so to speak, for a specified length of time.

[MORE ▶

When the trial period has elapsed, the surgeons who have worked with the new man should have the right to assess his work and to pass down a collective decision as to what his abilities and limitations are. They should, for example, determine whether he should be limited to abdominal surgery, or whether he's capable of doing traumatic surgery too.

Of course, a patient with heart disease or a woman suffering from eclampsia should get as careful attention as the patient who is to have his abdomen opened. So the above method should also apply in handing out privileges in obstetrics and internal medicine.

Unknown Surgeons

Not long ago, a colleague told me about a recent experience at his local hospital. Two new surgeons had opened practice in the town within weeks of each other. Their abilities were unknown to the hospital administration. But since both men claimed long and extensive surgical experience, both were given an opportunity to do supervised surgery, pretty much in accordance with the method I've just outlined.

In less than two months' time, it was clear that one of the surgeons was incapable of doing safe abdominal operations. The result: He agreed not to attempt such surgery in the hospital.

The second man, given the same opportunity, soon proved that he was as competent as he claimed to be. So his operating privileges were laid out accordingly.

The Best Test

In adopting this method of determining hospital privileges, *you're* not limiting the man. Instead, you're expressing confidence that *he* will limit himself.

You don't say: "You may take out an appendix or a gall bladder, but you may not do brain or chest surgery." You *do* implant in the man's conscience exactly what his professional shortcomings are. If he's honest with himself, he won't then attempt anything that he's not fully qualified to do.

The gap between specialists and generalists has lasted far too long. We now have a fine opportunity to close it tightly. As a G.P., that's my fondest wish. As President of the A.M.A., beginning this month, it's my dedicated objective. END

Itemized Billing: Simplest System Yet

Here's one doctor's report on a method that gets out 100 detailed statements in half an hour—and that costs under $50 to install

By Edward K. Isaacson, M.D.

Several months ago I decided to start sending my patients *itemized* statements. But I didn't want to increase my secretary's typing load or to spend hundreds of dollars for special equipment. So I worked out a billing system of my own.

In actual practice, I've found that it has these attractive features:

It's simple: My secretary doesn't have to do any typing at all to get out the monthly statements.

It's fast: It takes her only about thirty minutes to process 100 bills.

It's cheap: Necessary equipment cost me less than $50 in all.

Here, briefly, is the essence of my system: Patients' names and addresses are printed on statements by means of a hand-operated addressing machine. Charge slips,

which were itemized at the time of the patients' visits, are folded within each statement. And the statements, with charge slips inside, are mailed in window envelopes. That's how all end-of-the-month typing is eliminated.

To install such a system requires just one thing: A master address stencil must be prepared.

Roll-Type Stencil

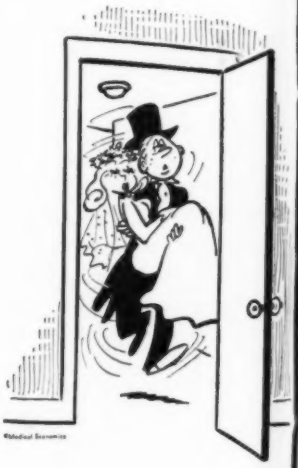
To do this, the aide types the names and addresses of all patients on the long roll-type stencil used in the addressing machine. As she types them, she numbers them consecutively. Thus, the first address on the roll has the number 1, the second 2, and so on. She also marks each patient's account number on his ledger card. (When new patients arrive, their names are added at the end of the stencil—and thus get the next highest numbers.)

During the month, our new billing routine requires very little extra work. When I finish with a patient, I fill out a charge slip and ask him to give it to the secretary on his way out. She merely transfers the charges to the patient's ledger card, marks his account number on the charge slip, and files both. (In our office, cards and slips are filed in separate boxes. And a metal flag is fastened to the ledger card to signify an account due.)

Three Simple Steps

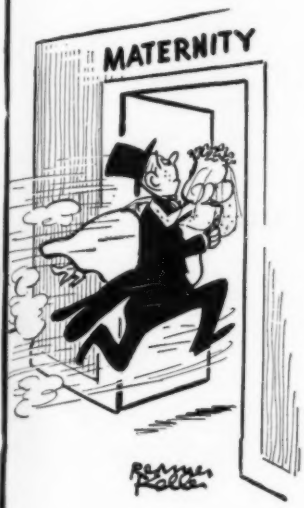
On billing day, then, there are only three steps for the aide to take:

1. She pulls all flagged ledger cards, arranges them in *numerical* order (they're filed alphabetically), and places charge slips with proper cards.



2. She turns the addressing roll to the number of the first account due. Then she prints that name and address on a blank statement. Inserting the statement and pressing the lever takes about three seconds.

3. On the statement, she writes only the total amount due (the sum of the charge slips). Next she folds the statement around the charge slips and puts the package into a window envelope, with name and address showing through. She's now ready to proceed to the next account due.



Simple? I think so. And inexpensive too, as I've said. Here's a breakdown of the basic costs of setting up such a system:

Bargain Prices

The addressing machine I use (plus necessary accessories) set me back about $30. Charge slips cost me 10 cents a hundred. We ourselves stamp them with a selected list of procedures. For this we use a rubber type-set stamp ($6). The metal flags cost about $1 a hundred. Total expense: less than $50.

Any drawbacks? Just one I can think of: Some doctors may object to the appearance of the stamped address. As you'd expect, it has a somewhat "mimeographed" look. But as far as I can judge, this hasn't bothered my patients in the least.

Doctor Does It

And to offset any such minor objection, there's this big advantage: The system is so simple that if the secretary's absent at billing time, the doctor himself can get out the month's statements with ease.

I know. I've done it on two occasions without even soiling my fingers. END

How Many Specialists Today Are Certified?

These percentages of full-time specialists are now certified:

These numbers of full-time specialists are now certified:

Specialty	Full-Time Specialists*	Number Certified†
Internal Medicine	16,321	8,387
Surgery	12,593	6,096
Obstetrics/Gynecology	7,198	4,146
Psychiatry/Neurology	7,048	4,492
Pediatrics	6,567	4,733

*As reported by the A.M.A. in its American Medical Directory, 1955. †As reported

Specialty	Full-Time Specialists*	Number Certified†
OALR/ALR	5,970	3,900
Roentgenology/Radiology	4,249	4,153
Ophthalmology	3,694	3,409
Orthopedic Surgery	3,083	2,237
Urology	2,746	1,696

*A.N. Marquis Company, publishers of the 1955 Directory of Medical Specialists.

He Practices the 'Medicine of Tomorrow'

This physician has built a solid practice on the basis of annual physical examinations and health maintenance. Here's his method

By Wallace Croatman

In medicine, where the sixty-hour week is the rule, Robert B. Marin is remarkably free from the usual pressures. He's a successful internist who sees only five or six patients a day. His evenings and week-ends are usually his own. On weekdays, his office hours run from 8 until 1. His afternoons are free for consultations, hospital work, teaching, attending lectures, or anything else he chooses to do.

He's constructed a modern-day practice around the age-old axiom that an ounce of prevention is worth a pound of cure. Many a G.P. or internist could run his practice in this way, he contends. Dentists have sold patients on the value of semi-annual visits; pediatricians have convinced mothers that babies need periodic examinations. Why shouldn't other doctors educate adults to the value of carefully done check-ups?

Dr. Marin has practiced this sort of medicine in Montclair, N.J., for more than a dozen years. Obviously, he is sold on it. And so are his patients.

The byword of his practice might well be "Take your time." The careful diagnostic study he does on all new patients consists of a detailed medical history, a thorough physical exam, a complete blood count, sedimentation rate, urinalysis, electrocardiogram, and basal metabolism. His routine takes three hours or more to complete, not counting the time spent later in analyzing the results.

When the doctor completes his studies, the patient returns to the office to have his case reviewed. If any disorder has been turned up (and at least some minor defect is revealed in nine cases out of ten) a treatment program is outlined. If necessary, the patient is referred for consultation.

The patient who's in good enough shape to be turned loose is reminded that he's to let Dr. Marin know whenever he runs into physical or emotional trouble. And, in any event, he's notified twelve months later, when it's time for his annual re-examination.

A dozen years ago, the doctor had trouble getting people to return for the yearly check-up. But his current patients are so conditioned to the idea that they need little prodding. The annual exam takes only half as long as the initial routine; but it's none the less thorough.

What's it like to be examined by Dr. Marin? A physi-

cian-patient who's gone through the experience describes it in the following words:

"This should not be confused with the belt-line type of physical given by some diagnostic centers. The unique flavor of this one is the feeling of being unhurried. Dr. Marin takes forty-five minutes just for the history. When he gets you talking about the most fascinating subject in the world (yourself), you find you're actually enjoying what could be—and too often is—a dreary business."

No-Charge Calls

In addition to examining the patient, the doctor acts as his "health agent." This rather ambiguous title may not seem to mean much; but here's what it *can* mean to the patient:

He's expected to let Dr. Marin know whenever he doesn't feel well. The doctor has a morning hour set aside for taking such phone calls, and he doesn't charge for this service. He finds that the privilege isn't abused. In fact, he says he has to urge people to keep calling.

When a sick patient does call, Dr. Marin responds in one of three ways:

If the complaint is a minor one, he tells the person what to do about it; if necessary, he orders a prescription. Such minor services are given without charge.

Which Specialist?

For more serious conditions that are clearly outside the realm of internal medicine, he decides which specialist should be called in. And he gets the appropriate man on the case at once. Here again, Dr. Marin's services are without charge.

If the case is within the scope of internal medicine, he handles it himself by either a home or an office call. For such calls, he charges the conventional fee.

Actually, Dr. Marin has to make only a handful of house calls during the course of a year. How come? "Well," he explains, "for one thing, I don't take patients under 15; so I get none of the childhood emergencies that keep some of my colleagues hopping. Also, my system of phone calls and referrals cuts down considerably on the volume of potential house calls."

When people get periodic physical exams, he insists, they also get *early* treatment of potential disorders. So emergencies

are less likely to arise and the amount of sickness diminishes.

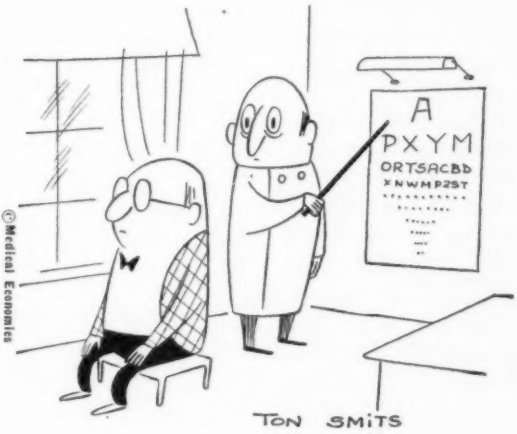
Does his work as "health agent" add up to an economic loss? Dr. Marin says not. His fee for the basic health examination has been pegged high enough to absorb the additional demands on his time. (His regular charges to private patients: $100 for the complete physical, $50 for the annual re-examination.)

These rates are scaled downward when the patient's financial situation indicates. But the doctor finds that most people are willing to pay the full cost of thorough examinations.

When Dr. Marin first began specializing in preventive medicine, some of his colleagues predicted he'd starve. But he kept at the idea, advising—if not quite *requiring*—every new patient to have a complete physical. Today the check-up *is* a requirement: He won't accept an individual who declines to undergo a health survey.

More than half his new patients are referred by other patients. So it seems clear that the public likes the doctor's methods. (Some even more tangible evidence of patients' approval: His collection percentage, he reports, is "practically 100 per cent.")

Naturally, there are skeptics



who don't believe that any physical exam could be worth $100. Dr. Marin looks on such individuals as a challenge. "It's one of my main jobs," he points out, "to *educate* the public to the value of thorough medical care. I feel I've failed with a patient if he isn't soon convinced of the advantages of discovering a disease *early*."

Why They Come

The town where he practices has a population of about 50,000; but Dr. Marin's patients come not merely from Montclair. They come from all over the New York metropolitan area. An observer has to conclude that people from Connecticut, Long Island, and other fairly distant points come to him because no doctor in their area offers this type of service.

One woman even comes all the way from Mississippi for her annual check-ups. She was first examined by Dr. Marin a few years ago, while she was visiting a friend in New Jersey. And she's been coming back ever since.

Today, far from having trouble finding enough patients to examine, Dr. Marin has a hard time fitting them into his schedule. Since he sees only about thirty-five a week, there's only limited room for newcomers.

One a Day

Not all thirty-five patients get physicals, of course. The doctor rarely does more than one three-hour physical, or two hour-and-a-half rechecks, in a given day. A typical day's schedule might include one three-hour patient, one patient who's simply given the results of his tests, and three or four who get some type of minor treatment.

This leisurely flow of patients is handled in a spacious eight-room office suite. The layout includes a small laboratory, three examining rooms, and a room for Marin's nurse, in addition to the consultation and reception areas.

The largest examining room is generally reserved for three-hour examinations. Another room is used for examining women patients, another for routine check-ups and treatment, and another for ECGs and BMRs.

All-Around Girl

He employs only one aide, who acts as laboratory technician, nurse, receptionist, and all-

around Girl Friday. The secretarial aspects of the job are less burdensome than you might think. Record-keeping, for example, presents no particular problem. For each patient there's merely a conventional folder. Into it goes everything relevant: Dr. Marin's notes, lab reports, reports from other doctors. The folders are filed alphabetically in a couple of cabinets—and that's about all there is to it.

Service for Industries

As an offshoot of his private practice, Dr. Marin has for the past six years been offering a special "executive diagnostic service" to businesses and industrial plants. Under this program, executives are examined on an annual basis, with the company picking up the tab of $100 per exam. The service is basically the same as that for the regular patients, except that the executives are referred to their own doctors for subsequent treatment.

The program grew out of a talk Dr. Marin had, several years ago, with a friend who happens to head a near-by business. The company was going through a rapid expansion at the time; and as a result of the accompanying tensions a number of its executives were showing the strain.

Dr. Marin broached the idea of examining the top men on an annual basis. "I believed," he recalls, "that men under pressure need periodic reassurance on the state of their health. But I also felt that the examinations must be entirely voluntary and that the results must not be released to company officials. The company agreed—and sent me ten men as a trial beginning."

At first, he says, the executives "came with trepidation, wondering if this thing was on the level." They soon found out it was: The company wasn't trying to weed out the less healthy specimens; it simply wanted to keep its valuable executives functioning at peak efficiency.

White-Collar Work

Dr. Marin now examines sixty executives and department heads for this particular company. He also does company-paid physicals on men from other firms. And no employer ever gets as much as a word of official report for its $100-a-man investment!

As Dr. Marin explains it: "The top echelons know more about the physical capacity of the indi-

vidual today than they ever did before. But none of their information has come through the back door from me. It has come from the men themselves.

"The less you demand of a person, the more he'll tell you. We put no pressure on the men to say anything. In other words, they can discuss their business here, their jobs, their bosses, anything they want, and not a word goes any further. They're perfectly free to do it, and they do."

Why It Pays

Does Dr. Marin see a real future for preventive medicine of the kind he practices? "I certainly do," he says. "Here's why:

"The growth of specialization in the last thirty years has put the average patient in the position of not knowing where to find a doctor who'll see the forest instead of just the trees. The resultant dilemma is this: Should the patient make his own diagnosis and choose a suitable specialist? Or should he attempt to consult the hurried and overworked general practitioner?

"To add to the confusion, the patient is told in magazines, newspapers, and over the air that early diagnosis and complete physicals are the best defense against cancer and other serious diseases.

"But he finds it difficult to get the necessary examination from a G.P.; and to cover the whole anatomy would require ten specialists.

"It's just such patients—the ones who want a physical exam but honestly don't know where to get it—who form the nucleus of my practice. And they can add up to a successful practice for many another doctor."

Dr. Marin feels that in the next two decades the annual physical will become accepted as routine by the majority of Americans. What concerns him is that lay organizations, rather than individual physicians, are making the major promotional efforts.

Job for G.P.s

He's convinced that many more family doctors should be offering this type of service. What's more, he's convinced that they *will* be offering it in time.

"Maybe it will take twenty years or more before preventive medicine comes into its own," he says. "But that day *is* coming. For my patients and me, at least, it's already here." END

How You Look From Capitol Hill

A revealing interview with Dr. Walter Judd of Minnesota, the medical profession's ranking representative in Congress

EDITOR'S NOTE: When Walter H. Judd speaks, smart people have learned to listen. He spoke in some 500 cities just before we entered World War II, alerting Americans to the conflict he saw was surely coming. He'd been a medical missionary in China and his shrewd observations there served his country well. Now, in this exclusive interview with Lois R. Chevalier, the M.D. from Minneapolis applies the same sharp scrutiny to the medical profession today. Listen . . .

Q. Dr. Judd, you've been away from the active practice of medicine for a good many years—enough to gain some perspective on the questions confronting medicine today. What do you notice now about doctors?

A. Well, I'm by no means cut off from doctors. I see a number of them and talk to them. And I think what I notice most is that they often lack breadth of vision. A doctor has such an intense interest in what he's doing clinically. He works such long hours and he pays such

close attention to his own patients that he sometimes fails to take the longer view.

Q. What do you mean by that?

A. I mean that the price he often pays for outstanding clinical proficiency is narrowness. As I look back on Dr. Will Mayo, the thing I admire most about him is that he saw so much—and so far in advance of his time. He foresaw the rise of specialization and the problems it would create. He devised a means of gathering all specialized skills under one roof so that the patient could have the most thorough care at a reasonable price. I use him as an illustration because he was a pioneer in surgery, medical education, medical economics, medical research. He had all these interests and he managed to keep them in balance.

". . . What makes them good specialists sometimes makes them poor citizens . . ."

So many doctors work only at their own things. They won't get into politics; they won't discuss issues with their patients; they won't even bother to vote; they just go ahead and work. They're good in their profession. But what makes them good specialists sometimes makes them poor citizens.

Q. As a Congressman, don't you get much response from the medical profession?

A. On medical issues, yes. But not much from individual doctors on nonmedical issues. When the A.M.A. stirs them up, they'll write me a lot of letters. But only about those bills that affect medicine.

Doctors seem to concentrate on their own interests more than most groups. I don't say this critically; it occurs as a result of their specialization. But we get less mail from doctors on general issues—international policies, farm policies, education, etc.—than from practically any other group in our population.

Q. When a health issue comes up, do you hear from doctors

only at the instigation of organized medicine? Or do they also write in on their own?

A. Both. But mostly they write when the secretary of the state medical society or of the A.M.A. sends out a call: Get hold of your Congressman and tell him so-and-so.

Q. Do you get much variety of response from doctors on issues affecting the health field?

A. No, they usually stand pretty united. I think doctors pretty largely have the same point of view.

They have lived together through medical school, in the medical society, and in the hospital staff rooms. They have a cup of coffee while they're in the OB rooms waiting for a baby. They're very much confined to their own group. They talk things over and little by little they come to think alike.

Q. You feel, then, that the average doctor doesn't mix enough with the outside world?

A. That's right. He ought to be more like the barber and talk to his own patients. The barber talks to you about everything. But the doctor talks only about your gall bladder or your toenail. You find very few doctors discussing political or social issues with their patients.

"...Doctors seem to concentrate on their own interests more than most groups..."

Q. That's an interesting point. Certainly the doctor is in a wonderful position to have his finger on the pulse of the public if he wishes to.

A. There are exceptions. There are some doctors who are up to their ears in politics. I have a couple of doctors on my committee at home. They're for me *not* because I'm a doctor—they'd have been for me if I'd been a grocer—but because they're interested in my point of view. But the profession's rank and file seem preoccupied with their own duties and interests.

Q. How do you feel, Dr. Judd,

about the cost of medical care? What should be our approach to this problem?

A. Well, American medicine has become so good that it's now pretty expensive—at least in some cases. We've learned so much that we keep people alive until they die of some long degenerative disease. Almost everyone faces a prohibitively costly illness at the end of life.

Our only answer is more and better insurance. I know it isn't as popular as complete coverage, but I favor the so-called catastrophic policy—the kind with a $50 or $100 deductible provision. After all, anybody who's employed can pay the first $50 or $100 of his medical bills. It's the big bills that people need protection against.

". . . You don't want medical decisions revised by gum-chewing clerks . . ."

Q. You spoke of group practice as an advance in medical economics. Would you consider group practice with prepayment as a further advance?

A. Well, there are many different ways of organizing prepayment. Certainly Blue Shield and Blue Cross have taken care of the most people over the widest areas. But I think the test of all health insurance is whether or not the doctor works directly for the patient. The patient should be the boss. The doctor should be responsible to the patient or his family, not to some third party. Otherwise the most precious part of the doctor-patient relation is gone.

You don't want medical decisions revised by gum-chewing clerks. That's what we all fear when we speak against socialized medicine.

Q. Take a group-practice clinic such as Mayo. Is the doctor there responsible to the patient or to the organization?

A. Well, it's an organization of *doctors*. It isn't run by politicians or other lay people. There's a world of difference.

Q. Would you say there's a difference in quality between Blue Shield and the commercial health insurance plans?

A. I don't know too much about commercial health insurance plans. I know there have been difficulties with some of them. Whether that means the bad eggs in the basket give a bad odor to all the others, I don't know.

I have had considerable experience with the Blue plans. On the whole they've been very successful and helpful. And one reason seems to be that Blue Shield and Blue Cross are spark-plugged by health people.

Q. As you probably know, about 35 per cent of the doctors in this country are working on a full- or part-time salary now. What do you think of this development?

A. Well, doctors are like other people: Most of them need an incentive. I believe there's more incentive in the fee-for-service basis.

After all, there are two main incentives for a professional man: income and professional advancement. In the long run, I think the latter is more compelling, in spite of everything that's being said nowadays about doctors being money-hungry.

Q. Why do people call doctors money-hungry?

A. First of all, because some of them are. You can't deny it. But I honestly don't think it's as bad as people think it is.

You see, there are two factors working here. The cost of medical care is higher—because it has improved so much in the past twenty-five years. But that isn't all. There are some few doctors who are taking advantage of the situation.

I think the ones who cause the most comment are the younger doctors who show too much evidence of prosperity too quickly. I mean, for instance, the man who's been in practice three or

". . . It takes great wisdom to be rich without being hated . . ."

". . . They resent the young man who seems to be making a pile within a couple of years after he sets up in practice . . ."

four years and already has a big car and a house in the most fashionable suburb. People resent that. It's pretty hard to become prosperous that fast and still be well-liked.

Q. Do you think this holds true for older doctors too?

A. Oh, no. People expect the older doctor to be financially successful. They'd probably think there was something wrong with him if he weren't. The American people respect financial success. But they resent the young man who seems to be making a pile within a couple of years after he sets up in practice.

Of course, I know what these young doctors say. They talk about the investment they've made in their education and training. And it's true. But the public doesn't see it that way. And this isn't surprising.

It's like Americans telling some hungry people in Asia about the wonders of our economic system. Sure, we've worked hard to earn our prosperity. And we're the richest country in the world. But that doesn't make other people like us. In fact, it makes it harder for the rest of the world to like us. And we don't use enough restraint. It takes great wisdom to be rich without being hated.

Q: Do you think that professional advancement and income have the proper relationship to each other in medicine today?

A. In general the greater the professional distinction, the greater the monetary reward. But that isn't the main reason why doctors want to get elected as head of the medical society, for example. They primarily desire the approval of their colleagues—the highest kind of approval, because you can't fool your colleagues. The highest praise that can come to a doctor is to be

called on by other physicians when they're sick.

Q. Dr. Francis Hodges in California once wrote a very interesting article about "the right to die." Do you believe that modern medicine sometimes keeps people alive when perhaps there's no real purpose to it?

A. We've got the old Hippocratic code that says we must preserve life. We aren't adjusted to the fact that our new drugs keep people alive whom Nature, if left to herself, would mercifully take away. We put them in oxygen tents, fill them full of antibiotics, and keep them going.

I had a relative who was kept breathing that way for four and a half years at a cost of more than $10,000. We kept her alive because the only values we know are to keep people alive. And yet she was dead, except that her body was still functioning by artificial means. She didn't recognize anybody; she didn't know anybody. They fed her with a tube for four and a half years.

Q. How can we cope with this problem?

A. I don't know an answer that's good enough. The religious and social forces haven't developed new standards that they've been able to agree upon and present to the public in a convincing way. So we go ahead with our medicine in the jet age—but with our social customs in the horse-and-buggy age.

Q. But do you feel that medicine can really do very much to solve this social problem?

A. Medicine's got to keep hammering away at it, because medicine created it. Doctors are the ones who keep these patients alive; they ought to be working at the problem more creatively, with greater imagination. We haven't paid enough attention to it.

[MORE ▶

"... Changes are being made. We can't escape our responsibilities by just doing our medicine and surgery ..."

As I said in the beginning, we're citizens as well as physicians. We're living in a world where changes are being made. We can't escape our responsibilities by just doing our medicine and surgery.

Q. One last question, Dr. Judd: Do you think there will be more group and partnership practice in the coming years?

A. Yes, I think so. Not so much because of the economics of it as because of the spirit of the shorter work week. This affects everyone, the doctor included.

In the old days, the doctor expected to be on call twenty-four hours a day, seven days a week. Now he wants to have time to travel, to be with his family, to get in some post-graduate work and some recreation. There's no other way he can get it and still do justice to his patients except through group and partnership practice.

I know how hard it is to practice alone. I did it. While there'll always be some highly individualistic men who prefer to be completely on their own, they'll be fewer and fewer, I think.

Some day I'll probably go back to medical practice, because I like it. I guess I may as well admit it: I'll probably practice alone. I'm one of that kind. END

Apprentice System

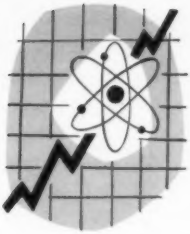
I poked my head into the reception room of the office I share with a considerably older associate. It was almost time to close up for the day, and the room was empty except for an elderly matron sitting on the couch. As soon as she spotted me, she raised her forefinger and said to me imperiously:

"I want to see Dr. Thompson [the senior associate]. Go and tell him I'm here."

It had been a rough day. My disposition was getting frayed.

"Who do you think I am?" I snapped back at her. "His office boy?"

"Why, yes," she said. "Aren't you?"—W. A. JOHNSON, M.D.



Invest in Atomic Energy?

If you're asking yourself that question—as many doctors are—you're likely to profit from this cool analysis of a hot topic

By Thomas Owens

Investment men have enthusiastically welcomed the Government's decision to release $1 billion worth of Uranium 235 for commercial use. One financial writer goes so far as to say: "Atomic development is *the* industry of the future. Investors who climb on the bandwagon now can expect to realize fabulous profits."

It's true that the atomic industry seems to be about where auto manufacturing was in 1910, or where television was ten years ago—on the threshold of a tremendous future. But here's a word of caution: Many conservative authorities expect the industry to tarry there—on the threshold—for another decade or more.

So before you put your savings into atomic development, you'd better take a good look at what's happening throughout the field. Then, if you *do* climb on the bandwagon, you'll know where it's heading. For instance:

How much progress has actually been made so far in the development of peacetime uses of the atom? What's the outlook for both the near and the far future? And what's the best course of action for you, as an investor, *right now?*

Two Major Types

Naturally, no one of those questions can be answered fully in a short article like this. But as a starter, let me give you the current viewpoint of experienced investors.

First of all, it's important to distinguish between two major aspects of atomic development: (1) the use of derivative radioactive materials (isotopes) in science, medicine, and industry; and (2) the use of nuclear material as "fuel" for the production of electrical power.

One Best Bet

Only the second of these aspects has much meaning for the investor. Isotopes may prove valuable for the development of other industries; but the big potential profits of the atomic industry itself are to be found in the use of nuclear material as fuel.

Unfortunately, that's where the big *problems* are, too. The technical stumbling blocks are formidable. The Atomic Energy Commission estimates it may take ten years—and billions of dollars—to build nuclear-fueled plants that can produce electricity as cheaply as most present-day coal and hydro-electric plants.

Huge Profits Ahead

When the atomic industry does get rolling, profits should be immense. In twenty years, about one-quarter of the nation's electrical power will probably be produced atomically, according to present estimates. And companies that mine and process the nuclear material, or that design and construct the new equipment, are likely to show fat earnings by then.

But even here there's a risk for the investor. Competition is already keen. A recent study listed almost 200 companies engaged in some sort of serious atomic development. There's no certainty that any one company will survive the hard days ahead.

Because the field is so crowded, many investment advisers recommend buying shares only

in older companies that are already well established in other lines. Great corporations like General Electric, Westinghouse, and General Dynamics are now branching out into atomic development. You can't go far wrong if you concentrate on such "blue chips," say the investment men.

Their advice seems sound: It's logical to assume that a major corporation with solid earnings from its present line will also be able to make its atomic ventures pay off. What's more, the doctor who puts his money in such stocks benefits from the company's non-atomic work while awaiting the nuclear pay-off.

The Questions to Ask

Even in buying the blue chips, though, caution is advised. One investment counselor recommends that you get answers to three questions before you make a final choice of company:

1. *Is the company* actively *engaged in atomic development?* Investors sometimes jump the gun. They rush to buy into a corporation whose interest in atoms is so far limited to research and preliminary investigation.

Take, for example, what happened when the Bath Iron Works —an established shipbuilding concern—hired a nuclear engineer. The management stated publicly that the firm had no atomic work and didn't expect any. But many investors must have imagined there was an atomic-powered ship ready to be launched. Despite the company's disclaimer, the price of its stock shot up 25 per cent.

Who Benefits?

That may have been fine for the man who wanted to *sell* his stock in Bath Iron. But I doubt whether it made the stock a good *buy* for the investor who hoped for appreciation as a result of atomic development.

2. *Is the company's atomic program a possible source of* substantial *profit?* Many of the firms that now build plants or supply materials under contract with the Atomic Energy Commission are earning only a small profit from such work. And their profits from these A.E.C. operations will probably never grow much larger. So you'd want to invest in such companies only if you expected them to branch out into extensive non-Government atomic work, in which they might earn bigger profits. [MORE ▶

3. *Has the company's atomic interest* already *sent its stock zooming too high?* It may take years, for instance, to justify the steep prices now being paid for shares in companies handling lithium (a rare metal used in atomic work).

Actually, you may feel that current high prices—whether justified or not—are a bar to buying *any* sound atomic stock. For the higher the price, the fewer companies you can invest in. And many seasoned doctor-investors believe that diversification is a prime safety factor.

Consider Mutual Funds

If you're of that opinion, here's a suggestion for you: Consider buying shares in a mutual fund that concentrates on atomic investments. There are several such funds. They load up their portfolios with shares of the solid, older companies and the most promising new companies in the atomic field. That way, they avoid putting all your money in one basket.

And they're also equipped to do some of the research you haven't time for. To help direct their choice of investments, they employ nuclear and geological consultants whose job it is to keep in touch with developments in the atomic field.

So it's not surprising that a fund's portfolio is bound to include many stocks—foreign uranium mines, for instance, or equipment makers—that the average doctor would probably never hear about, much less purchase.

50% Profit

The specialized atomic fund, while relatively new, has already become extremely popular. One fund, for example, started in 1953 with assets of only $100,000. In the next sixteen months, investors poured more than $40 *million* into it.

Their confidence seems to have been justified: The shares they bought in 1953 for about $10 each were selling less than two years later for almost $15.

But don't take it for granted that you'll have a similar happy experience in the atomic-investment field. There are plenty of risks in it. If you decide to take the plunge, you may well reap rich rewards. But don't forget that *nothing* in the stock market—not even a peaceful atom—is sure-fire. END

Red Man's Friend

This Midwest surgeon has built a remarkable spare-time career: He's adviser and occasional doctor to nearly 70,000 Arizona Indians

By Edwin N. Perrin

One day not long ago a white man and an Indian boy walked briskly into the abandoned Army hospital at Chinle, Ariz. They went straight to the disused operating room, where the white man removed a fibroid tumor from the base of the Indian's neck. Then he took the boy, an orthodox Navaho, back to his tribal medicine man for the appropriate healing "sing."

The performer of the impromptu operation was Surgeon Thomas Noble, who for about forty years has been one of the best friends an Indian ever had. He doesn't regularly practice on a reservation. But at least twice a year he gets away from his busy Indianapolis office—and his paleface patients—and heads West for a stay among the Navahos and Hopi.

What's his role among these Arizona Indians? At various times he acts as medical man, political agent, and

group historian. In between, he carries on his hobby of archeology in a region that has more relics of the past than any other part of the U.S.

It was archeology that originally lured Tom Noble out West. In 1916, while still a medical student, he made a summer trip through the Southwest with a friend who wanted to buy a cattle ranch. While the friend was looking at Herefords, *he* was looking at ruins.

Delighted with his findings, he came back almost every summer to hunt for more. By 1955 he was noted in archeological circles

IN SAFE HANDS: On their way home from a political safari to Washington, six Hopi leaders stop off to recuperate in the Indianapolis, Ind., home of Surgeon Thomas Noble (second from right). "Our hands are safe with you," one of the Indians told the white doctor, and he meant it literally. Reason: The last time six Hopi leaders made a political trip, they came home with their hands chopped off at the wrist. That was when a delegation went to see the Spanish officials in Santa Fe, N.M., in the early eighteenth century.

as the finder of some eleven canyons where prehistoric Americans had lived.

But you can't hunt ruins on an Indian reservation for forty years without getting to know a good many Indians. Dr. Noble has got to know thousands. Today his interest centers more on the 4,000 Hopi and 65,000 Navahos now living in Arizona than on their cliff-dwelling ancestors.

Without infringing on the work of regular Indian Service physicians—or of tribal medicine men—he has become a sort of unofficial health adviser to many of the Indians. A few years ago he was appointed medical consultant to the Arizona State Commission on Indian Affairs. And he's working to cut the Indian TB rate—now ten times higher than the white man's.

Politically, Dr. Noble is a one-man lobby for the desert tribes. Last year, for instance, when six Hopi leaders made a trip to Washington to see Government officials, they traveled on funds raised largely by him. And they created a sensation on their way home, when all six stopped off in Indianapolis to see the doctor.

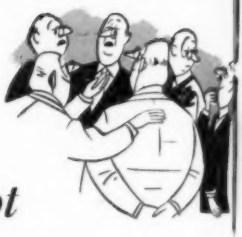
In Arizona itself, Dr. Noble and his wife (an amateur anthropologist in her own right) spend much of their time at Indian ceremonies. The doctor usually has a tape recorder with him; and when Indian custom will permit, his wife brings her camera.

"The old customs and ceremonies are fading fast," says Dr. Noble. "Industrial civilization is rubbing them out, and this unique way of American life will soon be gone forever. We're doing what we can to preserve some record of the best of it." END

Full Service

I'd delivered the illegitimate child of a young mountain girl and was filling out the birth certificate. "Who was the father?" I asked. The girl wouldn't speak.

Finally the girl's mother turned and said: "Doctor, just put *your* name down. It'll be all right."—M.D., GEORGIA



Could You Adapt To Group Practice?

The transition from solo practice often proves difficult, according to this analyst. Here's how you can test yourself in advance

By John R. Sedgwick

How long before you enter group practice? You may answer "Never!"—and your prediction may be right. But it's also possible that time will prove you wrong.

More and more medical groups are springing into existence. Those already organized are expanding. I'm convinced that sooner or later most of this country's medical services will be provided through some type of combined practice.

When it's time to leap aboard the bandwagon, a lot of doctors will make the jump easily. But others won't. They'll fail to fit into group practice—as many practitioners have failed before them—because of inability to shed certain solo traits.

THE AUTHOR, *a nationally known consultant on group practice, is directing the field research for the A.M.A.'s current survey of medical groups.*

I've been associated with various medical groups for eighteen years. During that time, I've observed again and again that the successful group practitioner is the man who learns to *share* responsibility with his colleagues. He learns this in three basic areas: medicine, business, and human relations.

The need for teamwork in group medicine seems self-evident. Yet it hasn't been for some doctors I've known.

I remember a Southerner with an independent income. He'd apparently joined a group mainly because it promised shorter hours than solo practice. He proceeded to shorten his working day to such an extent that he lost patients for the group. Ultimately, he was asked to leave.

Some solo practitioners fail to appreciate that groups may have different philosophies of medicine from their own. Such men are apt to be unhappy in combined practice. And some groups take special pains to point this out:

"If you can't adjust your concept of medicine to ours, you'd better go elsewhere," I once heard an experienced group practitioner say to a younger man. He wasn't being arbitrary or dictatorial. He was merely warning the younger physician what it took to adapt.

I've seen what happens when young group physicians prove unable to accept the medical methods of their colleagues. One man, for example, began criticizing his seniors in public. Some of his lay friends lost confidence

in the group and took their illnesses elsewhere. The word went out that the group was in a bad way. And it was—until the young man was asked to return to solo practice.

Besides agreeing medically, group members have got to work together as *business* partners. They're on an economic as well as a clinical team. Yet some physicians shy away from "sticking their noses" into the group's business affairs when they first join.

One young doctor in a West Coast clinic had a habit of arriving late for business meetings. Sometimes he didn't turn up at all. When he *did* attend, he never opened his mouth. Finally, one of his senior colleagues told him the group was disturbed by his lack of interest in its business affairs. "We're all in this together, you know," he said.

The younger man explained: "I never did care much for business. The group ran well before I came. I don't see that there's anything I can contribute in a business way."

In spite of all the older men could say, the young man's lack of interest persisted. Eventually he was asked to resign, even though he was an excellent practitioner. The other group members couldn't afford the luxury of an apathetic business partner.

Consider, by contrast, the experience of a pediatrician who joined a Midwestern clinic. He discovered early in the game that the group disagreed over its profit-sharing system: The medical men believed it put too high a premium on surgery.

The young pediatrician avoided taking sides. But he talked it over coolly and impartially with *all* his colleagues. Pretty soon, both sides began to listen to his objective comment.

In a few months, he managed to suggest and put through a new method of income division. Today the group is flourishing as never before.

Calling Dale Carnegie

That man was an ideal group practitioner in his willingness to assume responsibility for making the group function more smoothly. He also knew how to get along with his colleagues *as human beings*. That's probably the most essential knack for any doctor who wants to succeed in group practice.

It's especially important for the younger [MORE ON 237]

The Doctor's Vacation Habits

[THE PRIVATE LIFE of the U.S. physician—his health, his family, his personal habits, his politics, his social activities, his community service, his recreation—is now being examined by MEDICAL ECONOMICS in a series of nation-wide polls. Upwards of 1,200 questions, divided into categories, are being asked of samples of male physicians in private practice. Each physician is given only one category of questions, but a total of 15,000 doctors will be queried in all. This is the seventh article based on their replies.—ED.]

If you're like the typical American physician, you took three weeks off from your practice last year. Piling the wife and kids in the car, you drove to a resort area where the kids could swim and you could fish. Your wife got a good part of *her* vacation by not having to cook. Though you disclosed your medical identity as little as possible, you were asked to treat at least one case of sunstroke or poison ivy. By the time your vacation was over, you'd driven 1,500 miles and spent nearly a thousand dollars.

That's how the *typical* physician vacations, according to MEDICAL ECONOMICS' latest survey. But there are a

good many surprising variations from the norm, and *you* probably accounted for your share of them.

So let's examine the findings in greater detail, beginning with the amount of time off that doctors take.

How Much Vacation?

The biggest trend in medical vacations is toward more of them. Almost half the doctors surveyed took at least two vacations last year. About 15 per cent took three or more. One man says he took ten vacations, each consisting of a five-day summer weekend.

Another big trend is toward spacing medical holidays all through the year. At any given moment of 1955, at least 5 per cent of the doctors surveyed were on vacation. The proportion of medical men away from their practices ranged from a 30 per cent high in August to a 5 per cent low in November and January.

Their average holiday was fourteen days long. But because of the trend toward multiple vacations, the average doctor spent twenty days away from his practice during the year.

Favorite vacation months, along with reasons for making them so, rank in this order: August ("too hot for work"); July ("children's school out"); June ("medical meeting time"); September ("resorts not crowded"); and October ("hunting season—autumn foliage").

As this listing suggests, doctors choose their vacation periods with an eye on the weather. Forty per cent say they are influenced mainly by this.

Only 20 per cent go during the period of lightest patient load. Only 9 per cent (including most obstetricians) have to schedule their vacations according to the dates on which their patients are likely to give birth.

Stoutly resisting all vacation trends are the 15 per cent of respondents who took *no* vacation in 1955. Many of these are young men just getting established in practice. But some older men still disdain vacations, too.

It appears that 5 to 10 per cent of U.S. doctors in indepen-

dent practice habitually work fifty-two weeks a year. A 61-year-old internist in Boston, for example, says he's never had a vacation in his life. And a North Dakota radiologist reports: "My last one was a four-day weekend about ten years ago."

Where the Doctor Goes

How does the typical doctor get away from it all? He drives off in his own car. (One New Jerseyite says he took his entire 1955 vacation in a taxi.)

Of those who drove, 70 per cent covered 1,000 miles or more. More than half this group put at least 2,500 miles on the speedometer.

Eighty-six per cent took their wives ("as ballast," said one man), and 40 per cent took their children. One per cent had only their dogs along.

Where were these doctors going? To the seashore (30 per cent), to the mountains (14 per cent), and to the Canadian backwoods (8 per cent), among other places. A few (3 per cent) put their cars on ocean liners and drove through Europe. But Florida, New England, and the Rocky Mountains drew the majority.

Among the individualists, a G.P. from New York spent a month on the Amazon River in a dugout canoe. Another New Yorker went to Mexico City as part of the Pan-American Olympic team. And an Illinois otolaryngologist stayed home, saying: "I've already been around the world twice and there's no place left to go." [MORE ▶

Three weeks' vacation for the typical physician and his family cost about $900. But one respondent with his own farm spent only $40 for a month's vacation. At the other extreme, a European traveler spent $10,000 on a three-month trip.

What He Does

How does a doctor amuse himself on vacation? Fishing is far and away the favorite diversion; it draws top rating from 25 per cent of the respondents. Sightseeing ranks second, followed by swimming, loafing, and golf. (A bare 10 per cent of the respondents went on a golf course even once during their 1955 vacations.)

What about medical meetings? Only 6 per cent attended a meeting during their main vacation. But 23 per cent managed to get to one during a shorter holiday.

Among the more unusual vacation activities: One man says he spent most of last year's vacation practicing the flute. Another played trombone in the town band of Concord, N.H. And one enterprising Californian enjoyed a cruise to South America as a ship's surgeon.

Fifteen per cent of the respondents habitually spend all their vacations "just loafing." Here's the full meaning of that phrase, as richly elaborated by a surgeon from Minnesota:

"I went to my 7½-acre island in Northern Minnesota and stayed 'in retreat.' I did *no* entertaining, slept without disturbance, fed

well, and read and read and read (nonmedical stuff only). I swam, fished, visited my Chippewa Indian friends—all this for six weeks. Have been doing this every year since my return from World War II. It's what I call really living!"

He's Still a Doctor

Almost half of all the doctors who take vacations travel incognito—that is, without disclosing the fact that they are doctors to any more people than they have to.

One Iowa physician goes so far as to tell new acquaintances he's an insurance agent. The small son of a Florida orthopedist has been trained to inform other hotel guests that his father's a funeral director.

Why these stratagems? To avoid a whole holiday talking about medicine. ("People want too much free advice," says a Pennsylvania EENT man who leaves his M.D. at home.) And in some cases to avoid scaled-up prices. ("Resort keepers charge doctors more than they charge other people," insists one doctor. "I've learned to take the caduceus off my car.")

But whether he conceals his calling or not, the doctor seldom gets away from medical practice altogether. Here are some incidents that respondents say have occurred to them while on vacation:

¶ A New Mexico pediatrician was asked for advice "by a somewhat anoxic person" atop Pike's Peak.

¶ Visiting a medical friend in Florida, a G.P. from Connecticut was prevailed on to cover for him while he attended a three-day medical convention.

¶ While sitting on a beach and painting in water colors, a California doctor was asked by a stranger to make some rough sketches for a proposed new medical building.

¶ While night-clubbing in New Orleans, a Wisconsin internist found himself massaging out a sudden severe cramp in the leg of a muscle dancer.

¶ A Wyoming G.P. claims he was asked by a farmer to treat a four-eyed bull for conjunctivitis. END

Showdown on Hospital Accreditation

Is the present method of judging hospitals basically worthwhile? A.M.A. investigators agree that it is. But they're still critical

By Hugh C. Sherwood

Should the Joint Commission on Accreditation of Hospitals be abolished? Should it be radically revamped? Or should it be credited with doing a good job—under difficult circumstances—of evaluating the nation's hospitals?

This month the A.M.A. is debating these questions. It's doing so following the report of a committee that has spent the past year investigating complaints against the Joint Commission.

These complaints have been building up ever since Jan. 1, 1953, when the American College of Surgeons turned over the task of hospital accreditation to a newly organized commission made up of representatives of five key organizations: the A.M.A., the A.C.S., the American College of Physicians, the American Hospital Association, and the Canadian Medical Association.

Since that date, the Joint Commission has accredited

or provisionally accredited more than 3,500 hospitals. But from accredited and nonaccredited institutions alike, a rising chorus of complaints has made it clear that many staff physicians have become dissatisfied with the commission's methods.

Just what are the doctors' criticisms? How do commission members answer them? And where does the A.M.A.'s investigating committee (known as the Stover Committee after its chairman, Dr. Wendell C. Stover of Boonville, Ind.) think the truth lies?

Let's begin with the complaints. MEDICAL ECONOMICS has just completed an independent study of doctors' experiences with the Joint Commission. The adverse experiences they report lead them to four main critical conclusions:

1. *Some requirements of the Joint Commission impose an unreasonable and unnecessary burden on hospital professional staffs.* Says a Wisconsin physician: "Most doctors in my area think too much is required of the physician and not enough of the hospital. They wonder, for instance, why the Joint Commission doesn't require a hospital to employ a specific number of nurses for a specific patient load. And they wonder, too, why it lets hospitals delegate certain important services, like pouring ether, to unskilled aides."

Other critics maintain that the Joint Commission requires too many staff meetings. One Minnesota prac-

titioner observes that "most doctors around here are active on the staffs of several hospitals. It's almost impossible for them to attend the required number of meetings at all of them."

Do Patients Matter?

Above all, the critical physicians told MEDICAL ECONOMICS, they're fed up with the amount of paperwork the Joint Commission demands. Says one practitioner: "This morning I spent five minutes giving a patient instructions on discharge from the hospital, and fifteen minutes filling out the face of the chart and recording proper code numbers for diseases and operative procedures."

Another doctor adds: "The care of the patient is being relegated to second position behind the use of pen and ink."

Most hospitals—particularly small ones—don't have the personnel to comply with the commission's record-keeping regulations, many doctors complain. As a Los Angeles physician puts it: "The Joint Commission should have a more flexible policy on medical records. It should consider local needs and local variations in the sizes, purposes, and qualifications of hospitals."

2. *Some of the Joint Commission's inspectors seem to be incompetent and/or dictatorial.* "They come here with a 'holier than thou' attitude," snorts a Texan. "And then they give the impression they don't know what they're talking about."

Another physician reports that "the last two inspectors who came into our area were totally unfitted for their jobs. They even lacked familiarity with the commission's own standards. The first one was in such a rush that he couldn't attend a luncheon that had been especially arranged so he could meet our trustees and the staff executive committee. The second one was in less of a hurry, but he apparently resented the very sensible questions that were asked of him."

'A Bad Name'

Many doctors believe the commission should have its own corps of inspectors, instead of relying on those of its member bodies. What's more, they feel, there ought to be *more* inspectors. They say that the combination of rushed inspectors and infrequent inspections sometimes gives a hospital a bad name for

longer than should be the case.

3. *The Joint Commission tends to stir up intraprofessional and intrahospital conflicts.* Says a Michigan practitioner: "Too much emphasis is placed upon board certification as a means of judging the qualifications of staff specialists. Many older doctors were simply given such certification. Many others—equally proficient—never applied for it. To this second group, it seems that the Joint Commission is acting as if *certified* meant the same thing as *competent*."

G.P.s, of course, are particularly upset by this. Says a California man: "We feel that our hospital privileges are restricted by arbitrary decisions not based upon observation of the work actually done. And we feel that the Joint Commission is primarily responsible."

Medical battles in various hospitals are also stimulated in another way, several doctors observe. A Minnesotan says: "The constant scrutiny maintained through elaborate records and through tissue and auditing

"Bite him quick. Show him who's boss."

committees inevitably sets one group of doctors against another." He goes so far as to say that the commission's requirements "force physicians to spy on one another."

Friend or Foe?

4. *The Joint Commission seems not to understand the problems of the local hospital.* According to an Iowan, "there's no practical method of appeal from its decisions. If a hospital is not accredited, nothing can be done until the next scheduled inspection."

Comments a West Coast doctor: "Many of us look on the commission as a group that's more inclined to penalize you than to help you solve your hospital problems."

"The Joint Commission does not truly represent *us*," observes another physician. "It has too many hospital people running it, and not enough doctors who have experienced active medical practice."

In short, according to a majority of the doctors queried by MEDICAL ECONOMICS, the Joint Commission needs to make its requirements more flexible; to develop a bigger and better staff of inspectors; and to show more understanding of local hospital problems.

These are serious statements. They deserve serious answers. So MEDICAL ECONOMICS has asked commission members to comment.

Here's how they reply:

"Admittedly, the commission isn't perfect. We'll grant, for instance, that we need more and better inspectors," says one commissioner. "And we'll concede, too, that we need a better administrative set-up."

Bound to Err

But the commissioners emphasize that the Joint Commission is only three years old; it was bound to make mistakes; and it has already corrected the more obvious ones. (Example: its abolishment this year of the complicated point system previously used in rating hospitals.)

"Then, too, the Joint Commission has never actually demanded some of the things it's accused of demanding," says Dr. Stanley Truman, one of seven A.M.A. representatives on the commission. "The trouble is, far too few doctors have read and studied the [MORE ON 218]

Congress Is Urged to Probe Doctor Shortage

A 'tremendous' rise in foreign-trained doctors in the U.S. is foreseen as a result of the limits placed on domestic medical school admissions

Able young physicians are currently so scarce in the United States that hospital representatives are beating the bushes to find internes in Europe and Asia.

So says Dr. Dominick F. Maurillo, chairman of the committee of licenses of the New York State Board of Regents.

Speaking before his state medical society last month, Dr. Maurillo asked that a Federal inquiry be made into the problem of "ceilings" placed on the number of students admitted to medical schools in this country. He called the present doctor shortage "very critical" and proposed that a national commission be set up to explore "all phases of medical education."

In 1956, said Dr. Maurillo, the number of foreign-trained physicians admitted to licensure examinations in the U.S. will equal one-third the number of doctors graduated by all seventy-two of the nation's medical

schools. And the trend, he added, is upward all the time.

About 5,500 unlicensed foreign doctors are now working as internes or residents in U.S. hospitals, Dr. Maurillo reported, and about 30 per cent of them are in New York. These doctors are invited to this country, or sent here as exchange students for a year or more, or come here to stay under the quota system, he said, adding that less than 10 per cent of them return to their native lands.

Here's a condensation of some of Dr. Maurillo's other points:

Half Go Begging

"Today there is a need for more than 14,000 internes because of hospital building in the last eight years and because so many residencies have been established. Last year our medical colleges graduated about 7,000 doctors. All these are serving their interneships; this leaves an interne shortage of 7,000.

"With the supply so small and the need so great, it's no wonder that hospitals want foreign doctors, even though their medical education is unapproved by state authorities. In fact, some hospital representatives travel to Europe and Asia to invite doctors as internes.

"These foreign M.D.s work on an equal basis with graduates of our domestic colleges. Some administrators and doctors who have worked with them and have formed a favorable opinion of their abilities protest vehemently against the policy of certain states in denying these physicians the right to take examinations for licensure.

"New York has admitted more foreign doctors to its medical licensure examination than any other state. In the five years before World War II, 5,055 of a total of 7,527 foreign-trained physicians were so admitted in New York. This was more than 67 per cent of the national total.

"From 1950 to 1954, New York admitted to examination 2,271 out of a total of 6,278 foreign-trained physicians, or more than 36 per cent.

"The foreign doctors admitted before World War II came mostly from Germany, Poland, and Austria. Today they come from all over the world, with the greater number from Europe, South America, and Asia.

"New York State has an experienced professional educa-

tional department. Its Board of Regents supervises the licensing of physicians.

"The Regents are often asked how they get information about medical education in other countries so they can judge the competence of men from those countries who apply for licenses.

"Before, during, and for some years after World War II, medical education was at its lowest ebb in a number of countries of Europe, Asia Minor, and Asia. Large numbers of the medical faculties had been drafted into the armed services and into essential industries. Many medical colleges had been destroyed.

"So it was hard for the Regents to get accurate information about the medical education given in those countries. Some reports indicated that medical diplomas could be obtained all too easily.

"Because of these conditions, between 1945 and 1951, the Regents denied a large number of foreign graduates admission to examination. Better to recommend denial and be safe, they reasoned, than to admit an incompetent doctor to practice medicine.

"From 1947 to 1949, about 300 veterans of World War II who could not gain admission to U.S. medical colleges went to Switzerland, Italy, France, and Holland for their medical education. Most of these students were residents of New York State.

Situation Improved

"Since the Regents were denying applicants from these countries, the veterans were worried about their status after graduation from foreign medical colleges. Happily for them, the Regents have the power to appraise medical education in any state or foreign country.

"In 1950 and 1951, the Regents received invitations from the ministers of education of France, Italy, and Switzerland to send a committee to evaluate their medical education. I was appointed chairman of the committee. As a result of its work, the Regents approved the medical education of eleven medical colleges in Italy, of five in Switzerland, and of the University of Paris Medical College.

"Later, the Regents' committee appraised medical education in Holland, England, Sweden, Germany, Greece, Turkey, Lebanon, Israel, Mexico, Cuba, and Venezuela.

[MORE ▶

CLISTIN IN NASAL ALLERGIES... HAY FEVER... POLLEN SENSITIVITY

CLISTIN IN PERENNIAL RHINITIS... DUST ALLERGIES

CLISTIN IN DRUG REACTIONS... URTICARIA... PRURITUS

"The Regents also had to solve the big problem of what action to take on physicians who came from unapproved medical colleges and who worked as internes in our approved hospitals.

"In 1951 and 1952, they approved courses in 'comprehensive medicine' at New York University Post-Graduate Medical College and at New York Polyclinic Post-Graduate College. These courses comprise an intensive, one-year review of medicine, involving the four-year curriculum of a medical college. They embrace practically all work in the basic sciences, plus bedside teaching and examinations.

"The Regents now recommend that most foreign doctors with an unapproved medical education complete (a) a one-year 'comprehensive course of formal study'; (b) a one-year, A.M.A.-approved rotating interneship; and (c) a one-year approved interneship or residency in either surgery, medicine, obstetrics and gynecology, or pediatrics. They may then take the New York State medical licensure examination. (New York is the only state that prescribes these conditions.)

"Of 25,000 doctors licensed and practicing in New York State, more than one-fifth are foreign-trained. And of the doctors doing general practice, more than one-third are foreign-trained.

"Here are figures showing the number of foreign-trained doctors admitted to examination in recent years (the figures for 1955 and 1956 are estimates):

1950	799
1951	1,066
1953	1,463
1954	1,642
1955 (est.)	2,000
1956 (est.)	2,500

"The estimate for 1956 equals more than a third the number that all our medical colleges combined will graduate this year. To put it differently, the 2,500 foreign-trained doctors admitted to examination will exceed the total product of twenty of our largest medical schools. And we can expect this number of foreign doctors to increase each year unless more are graduated from our American medical colleges.

"In 1955, Seymour B. Foreman of our research department reported to the Board of Regents that 5,826 doctors were gradu-

ated in the United States in 1945-46 and that only 6,861 doctors were graduated in 1953-54, after nine years. This is an increase of 1,035 doctors at the same time that the population of the United States increased by more than 18 million.

"He estimates that, with the great increase in college enrollment expected for 1956-70, more than 25,000 'B' (or better) students will have been kept out of medical colleges in the United States. Even today, there are more than two students available for every one accepted.

"This explains why more than 2,000 students are forced to study medicine outside the U.S.

"I have two concluding statements:

"1. The present policy of limiting the number of students for admission to our medical colleges is responsible for (a) the great increase in foreign doctors in the United States; (b) the 2,000 or more American students studying in foreign countries; (c) the growing shortage of general practitioners; (d) the discouragement of many potential medical students.

"2. Congress should pass a law creating a commission of experienced persons in this field to study the problem." END

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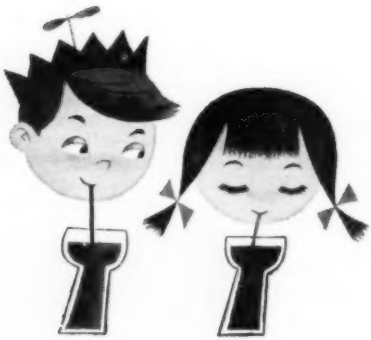

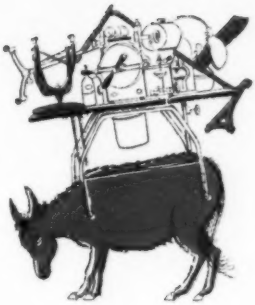

Don't Make a Move!

Don't, that is, until you read these tips. They're written especially for the doctor who's about to switch offices. File them for your future reference

By Edwin N. Perrin

Every year, about 7,000 U.S. doctors pack up their instruments and equipment, crate their medical libraries, and move to another state. An additional 10,000 physicians annually shift locations within their own states. The odds are that some time soon *you'll* be among the moving.

If you're like your average colleague, you'll have about two tons of office furniture and medical equipment to take with you. The most important single thing you can do to move it with the least possible bother is this: *Choose a reliable moving firm.*

Perhaps you've already had experience with one. If so, fine. If not, do some checking among your local colleagues. Most moving companies are perfectly honest; but there *is* a racketeering fringe. And since medical moves are more expensive than most, the vultures may be after your business. Probably the surest way to avoid

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Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia 25:67 1956. 3. Mitchell, E.H.: J.A.M.A. In press.

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them is to double-check with your local Better Business Bureau.

Once you've settled on a reputable firm, plan to spend some time with their estimator when he calls on you. It's his job to predict exactly how much time, money, and trouble your move will take—and to suggest ways your medical equipment can be made ready.

If you want the company to do all your packing and unpacking for you, he'll quote you a figure based on that. But if, like many

What It Costs to Move

A local move (from one office to another in the same city) will cost the physician about $100 in most places. That's if he has a three-room office and not too much heavy equipment. For X-ray and diathermy machines (which take special handling), he'll probably have to pay another $50.

A long-distance move costs from about $250 up. The physician who moves 4,000 pounds of equipment to a new office 300 miles away will probably pay the following approximate costs:

Transportation	$175
Transit insurance ($5,000 worth)	25
Packing and crating (including service)	125
Total	$325

Rates on interstate moves are controlled by the Interstate Commerce Commission. They vary only slightly from mover to mover. But there's no rate control on moves within a state. So in the latter case it's especially important to engage a reputable company.

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doctors, you prefer to do some of it with the help of your office staff, he'll arrange to have the proper boxes and barrels delivered to you well before moving day. The cost of the move should then be cheaper.

While thinking about cost, think also about insurance. Most movers are bonded and insured. But in an interstate move, their maximum liability is normally limited to 30 cents per pound. So if you have a $1,000 microscope weighing fifteen pounds, and if it gets damaged en route, the most you can recover may be only $4.50.

To get more protection, you'll have to buy transit insurance. The estimator can probably sell you a policy issued through his company; or you can get a commercial policy through any insurance broker. Either way, it should cost you about $5 for each $1,000 worth of property you're having shipped.

Once you and the estimator have settled such matters as packing procedure, cost estimates, and insurance coverage, his job is officially finished. But before he goes, don't fail to pump him for all possible packing tips.

Some companies make up a special list of these. For example, here's a list drawn up especially

DON'T MAKE A MOVE!

for physicians by Allied Van Lines, Inc.:

1. If you're taking your office laboratory refrigerator, have it defrosted well in advance. It should be wiped dry and secured for moving, with the motor bolted down.

2. Casters should be removed from appliances, equipment, and furniture. Each set should be put in an individual sack and clearly tagged to identify the piece it goes with.

3. All drugs and medications must be removed from drawers. It's best to keep such things in your immediate possession during short moves. If a long move is in prospect, your cue may be to use up or even give away expendable medical supplies.

4. Most instruments may be wrapped two or three together and put into packing barrels. But use plenty of stripped paper or excelsior.

5. Test tubes and similar glass objects should be individually wrapped. If nested, these glass items should be placed upright, not on their sides.

6. Stoppers of jars and bottles are best sealed with natural nail

polish, paraffin, or masking tape. Filled jars should go in a separate carton, just in case of leakage.

7. Framed degrees, pictures, etc. need protecting with a coat of paper before they're crated.

8. Your medical library belongs in extra-heavy cartons or crates. Place the books back to back, to keep the pages from getting interlocked and damaged.

Things Not to Do

1. Heavy items shouldn't be packed in drawers. Such packing may damage both the furniture and the equipment inside.

2. Mattresses ought not to be rolled. Instead, pack them in special cartons. These are usually available from the mover on request.

3. Inflammables of any sort must never be shipped by moving van.

4. Don't make the mistake of overpacking. Too much stuff in one box is the commonest cause of damage.

5. If you have X-ray equipment, don't pack the lead shielding that goes with it. It's usually far cheaper to get new lead sheets when you arrive. END

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How You Can Keep on Schedule

Make your aide responsible for the timing of appointments. In fact, make her a human time clock. This management consultant tells how

By Frances Marold

Dr. N was due back from his Rotary Club luncheon at 1:30. But he hadn't turned up by 2 o'clock. By then, his first patients were in the examining rooms, waiting.

They were growing restive when, at 2:10, Dr. N strode in. Almost on his heels came an unscheduled patient in need of immediate attention. In five minutes, still another patient arrived. She was on time for her appointment—and for a full hour's wait.

The last appointment had been scheduled for 5:30, but it was after 7 when the doctor finished. "It happens all the time," the aide told me later. "And to think—he's head of the medical society's public relations committee!"

Does *your* appointment schedule sometimes clog up like

THE AUTHOR *is associated with Professional Management of Waterloo, Iowa. This is the fourth of several articles by her on the doctor-aide relationship.*

Dr. N's? Do you sometimes wonder if it's humanly possible to see patients when you're supposed to? Then you'll be interested in what some other doctors have learned about getting more help from their aides.

He's the Boss

Take Dr. C. He's one of those men who's been able to master his schedule rather than be mastered by it. He does his part by arriving at the office a few minutes before the first appointment (except when delayed by rare emergencies). Once in the office, he relies on a timekeeper: his aide.

A detail man tells me that he once stopped in at Dr. C's office and found several patients in the reception room. Envisioning at least an hour's wait, he said he'd come back later. But the aide checked and found the doctor wanted to see him. "Dr. C will be right with you," she promised, ushering the man into the drug room. "But he can spare only ten minutes right now."

The physician joined him shortly; they transacted their business; and they were having a

How vital to their happiness . . . the mother's *health* ➤ ➤ With health, she can meet buoyantly and capably the demands of her family and her community. ➤ Upon her health and vitality rests the happiness of her family. She, in turn, depends upon the knowledgeable, experienced judgment of her physician in matters affecting her physical and mental well-being . . . especially on his advice on scientific methods of child-spacing. What more rewarding way for the doctor to expend his skill than in the perpetuation of the happy, healthy family. Hence, the significance of his recommending *Koromex*

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relaxed chat when a buzzer sounded. "Doctor, your next patient is ready for you," said the aide's voice over the intercom.

Doctor's Time Signal

Dr. C chuckled and said to the detail man: "I'm afraid my ten minutes are up. My girl really keeps things moving around here. Thanks for stopping by; see you next time you're in town."

When the detail man left, it was with the feeling that somehow the doctor would manage to see him next time. For here was a physician whose schedule was under control. A clock-watching secretary kept it that way.

Making your aide responsible for the timing of appointments is one help. Making her responsible for the appointments themselves is equally important. In my observation, too many doctors get unnecessarily involved here. For example:

One of our consultants noticed that a number of Dr. L's patients seemed to have a habit of dropping in unannounced and disrupting the schedule. Through careful observation, he discovered that they weren't just "drop-

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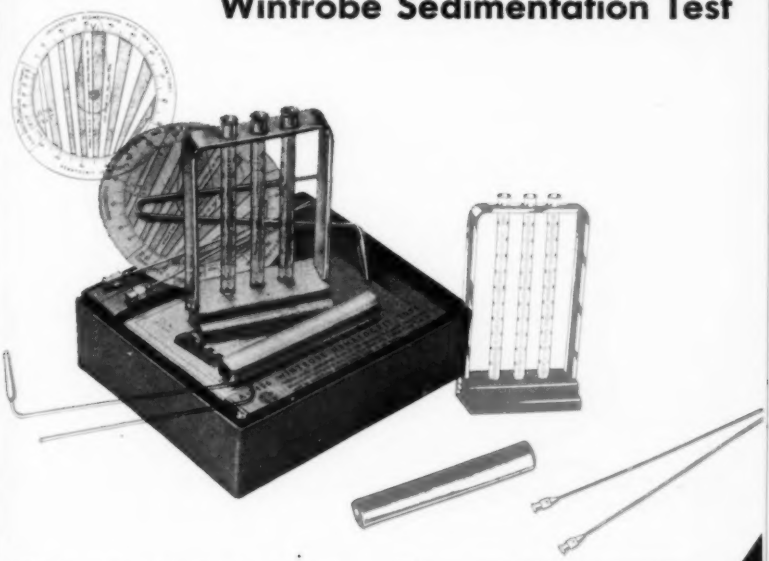

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- Adapters (2) for centrifuge shield to hold Wintrobe Tubes
- Cleaner for Wintrobe Hematocrit Tubes
- Syringe Cannulas (2) for Wintrobe Tubes

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ping in." Almost invariably, a casual remark of the doctor's had encouraged them to do so.

Mrs. Brown, for instance, had no appointment; and Dr. L's time was fully booked. But he had *promised* to see her, she told the aide. She explained that she had met the doctor at the club the night before and had complained to him about her throat trouble. He had thereupon said: "Drop in tomorrow and I'll have a look at it."

What could the secretary do but prolong the doctor's schedule for the day?

And what could she do about Mr. Jackson, who arrived soon afterward? He too had no appointment. But when he'd been discharged from the hospital, Dr. L had remarked: "Come around in about two weeks for a check-up."

The secretary kept her appointment book well in hand. But she couldn't provide for a succession of callers like these two—callers whom her employer had invited in without her knowledge.

"I pay my aide to set up an appointment schedule that protects both the patients' time and my energy," says one medical man. "So why should I sabotage what I'm paying for? I simply don't pass around invitations to 'drop in any time.'

"Instead, I've trained myself to say: 'Please call my secretary for an appointment next week, at a time that's convenient for you. Then I can see you without delay.'

"My patients prefer it that way. They don't want to wait around in my office. And I prefer it that way too. It gets me home to dinner on time." END

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One Snake or Two? Dilemma for Doctors

One of the two emblems symbolizing medicine has been branded false. The facts about Mercury's caduceus vs. Aesculapius' staff

By Helen C. Milius

How many snakes do you need, to signify that you're a physician?

One, according to the A.M.A. and assorted medical societies. *Two,* according to the Army and some other medical societies.

The discord has sprung from medicine's use of two distinct symbols. They have coexisted for years—each on its respective seals, diplomas, journal mastheads, and medical-building lintels. Yet specialists in medical heraldry say that only one is correct. The other is often denounced as erroneous, irrelevant, possibly libelous.

Whichever you use, the serpents have it all wrapped up. The staff of Aesculapius—choice of the A.M.A.—shows a single serpent spiraling along a knotty walking stick. The more elegant caduceus of Mercury—prescribed by the Army, for one—has a matched pair of

snakes intertwining around a knobbed and winged wand.

People who worry about such things are pleased that the caduceus seems to be losing out. Straws in the heraldic wind:

¶ The brand new insigne of Air Forces Medical Service physicians, breaking with the Army's caduceus tradition, is a stripped-down staff of Aesculapius.

¶ The caduceus that writhed for decades on the U.S. Public Health Service emblem no longer appears on the seal of the Department of Health, Education, and Welfare. Instead, Public Health is symbolized there by the single-serpent device.

Does this foreshadow a medical end to Mercury's swank symbol? Well, maybe it ought to, considering who he was. As the messenger of the gods, he carried the winged wand to identify himself to strangers. It came in particularly handy at deathbeds, for one of his duties was to lead expiring souls to Hades.

Mercury's subspecialties were even more disconcerting, from the modern doctor's point of view: He was deity of the market place, of the big deal, of the well-

The Snake in Medical Circles

An informal poll by this magazine indicates that American medical societies prefer the single-snake to the double-snake emblem by about three to one. Some societies, of course, don't have *any* serpent. And there's at least one county association that has adopted its own private snake, which stems from neither Aesculapius nor Mercury, but from an altogether different classical personage: Hygeia.

ONE SNAKE suffices for the Cleveland (Ohio) Academy of Medicine. Other such insignia, in various colorful forms, are used by state societies like Michigan and Florida, by counties like Multnomah (Ore.) and Sedgwick (Kan.).

lined wallet. Traveling salesmen and highway robbers operated under his auspices.

How did he get those reptiles shown on the caduceus? Well, the story goes that he found them at war and beguiled them into a mood for love. Then he induced them to hop on his staff and ride around, still embracing.

By contrast with Mercury, Aesculapius was a humanitarian. Legend has it that he began as a mortal, but that his skill as a doctor was so great that he antagonized Pluto, the ruler of Hades. Nobody was dying, and Hades was losing business. So Pluto had him struck down with a thunderbolt.

Then came Aesculapius' career as a god. At least two hundred temples were dedicated to him; and these became the first hospitals and medical schools of western civilization. He's still on night duty in the skies, outlined in stars as the giant in the constellation Ophiuchus (or "serpent-carrier").

How did this antiseptic healer get mixed up with snakes? His cult absorbed an earlier religion of snake-worship. The serpent al-

TWO SNAKES are shown here on the emblem of the American Medical Women's Association. Among others using similar caducei: the state societies of Arizona, Indiana, Iowa; the counties of Fulton (Ga.) and Northampton (Pa.).

PRIVATE SNAKE belongs to the doctors of Richmond County, N.Y. The goddess Hygeia holds it in honor of her father, Aesculapius. Normally she is shown feeding the serpent, but here she appears to be milking venom from the snake.

ready had a reputation for healing, based on its ability to shed old scars right along with its skin. And Aesculapian priests brandished snakes over their patients —who hastily pronounced themselves cured.

Worshipers believed his proficiency was hereditary. And his most illustrious descendant was, of course, Hippocrates.

How Mercury Got In

The A.M.A. rallied round the staff of Aesculapius in 1910; and others soon followed suit. Still, the caduceus of Mercury retains its adherents. How did it gain such respectability?

For one thing, alchemists of the Middle Ages made Mercury's trade-mark a symbol of the enigmatic metal that bears the god's name. And apothecaries hitched his name to a couple of dubious herbs, one of which is less classically known as poison ivy. But the winged caduceus seems to have been first used as a medical emblem by Sir William Butts, royal physician to King Henry VIII.

No one has attributed Sir William's choice to ignorance. Eru-

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The investigators report on a total of 109 cases of herpes zoster and 313 cases of neuritis, all of whom were seen in private practice. They attribute the prompt recovery from the disabling pain of these conditions to the fact that Protamide therapy was started at the patient's first visit. The shortening of the period of disability by this method of management they describe as "a very gratifying experience for both the physician and the patient."

HERPES ZOSTER—In this condition, which often results in disabling pain for prolonged periods, they report that "all but one of the 109 patients responded with complete relief of pain and healing of lesions." There was not a single instance of postherpetic neuralgia in any of the 108 patients who responded to Protamide therapy. Pain relief was prompt, and the duration of disability was greatly shortened, with the most

dramatic responses being observed in patients treated within a few days after onset of symptoms.

NEURITIS—Types of neuritis which in previous experience of the Drs. Lehrer had proved intractable and persisted for weeks despite therapy with Vitamins B_1 or B_{12}, analgesics, massage, and heat, were treated with Protamide. Excluded were cases caused by mechanical pressure on the nerve root. Instead of persisting for weeks as formerly, the disability from this type of neuritis was shortened to a few days when Protamide therapy was started at the first visit. Only one of the 313 patients in this series failed to respond with complete recovery, and none reported relapses.

CONCLUSIONS—Based on their extensive observations in this five-year period, the Drs. Lehrer comment on the "outstandingly superior" results with Protamide, and state that: "Protamide is now our therapy of choice in herpes zoster and radiculitis. Other methods of treatment have been discarded."

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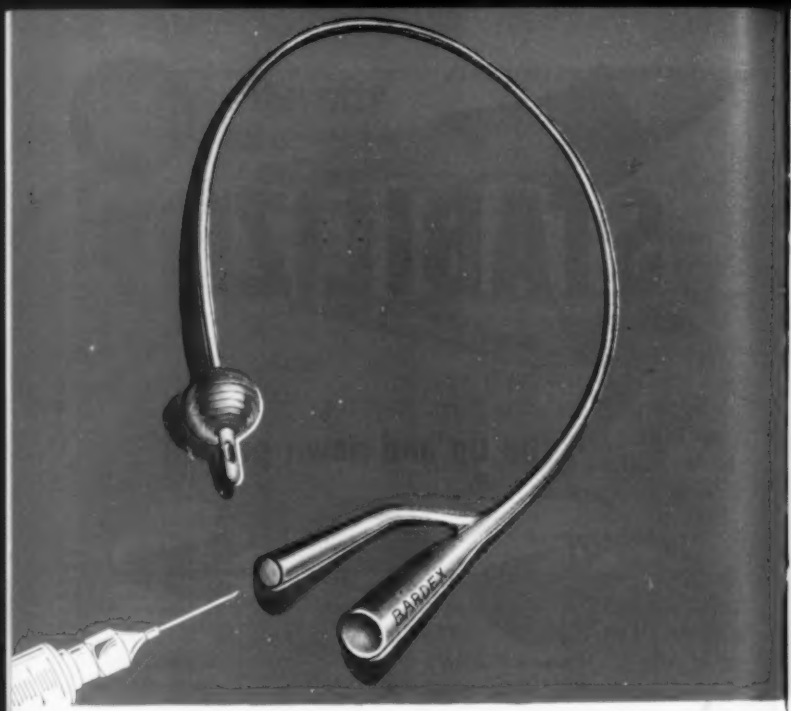
dition, in fact, could have been to blame. Fashionable physicians then carried gold-headed canes as visible tokens of Aesculapius' staff. This identified the M.D. and marked him for public deference. The cane was technically a caduceus (Latin for "herald's wand"); so Sir William may have decided, in scholarly fashion, that the royal physician deserved a caduceus with twice as many serpents as the ordinary doctor's, plus wings.

Army Debut

British physicians long ago dropped the winged caduceus. (The Royal Army Medical Corps, for example, pledges allegiance to Aesculapius' staff.) But it wormed its way into the U.S. Army a century ago, when hospital stewards stitched it to their uniforms. The Army made it official in 1902 for the Medical Corps. It has cropped up also at various times in insignia of flight surgeons, contract surgeons, the Dental Corps, Veterinary Corps, Army Nurse Corps, and Sanitary Corps.

By now, heraldic experts are forced to admit that this country's two medical emblems are both genuinely medical. They simply maintain that one is more genuine than the other. END



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If the Patient Gets Affectionate

It's great to be liked—but there can be too much of a good thing. Here are some ways to handle the overly friendly patient

By Brian Bird, M.D.

Some years ago, when I was fresh out of medical school, a woman patient led me to believe that she thought I was heaven's gift to medicine—and to her. I was sweet, she told me; I was charming; I was understanding. Never before, she said, had she met such a wonderful physician.

I suppose I should have been flattered. Come to think of it, I *was* flattered. What she said was heady stuff.

But it was too heady. It scared me stiff. This was no warm feeling of respect and admiration—the sort of thing that a good professional relationship is based on. This was away off center.

A short time later, I learned what was behind her effusiveness. Although the answer was a relief, I must admit

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THE AUTHOR *is Associate Professor of Psychiatry at Western Reserve University. He bases this article on the research done for his book, "Talking With Patients," J. B. Lippincott Company, Philadelphia, 1955.*

it was a letdown, too: She liked me because I reminded her of her favorite grandfather!

This case illustrates one cause of overfondness: The patient invests the doctor with qualities derived from other people who have been kind and helpful in the past.

Can You Live Up?

Unfortunately, the doctor is never *that* good. He just can't be as good—or as bad—as the imagined qualities of a dozen persons all rolled into one.

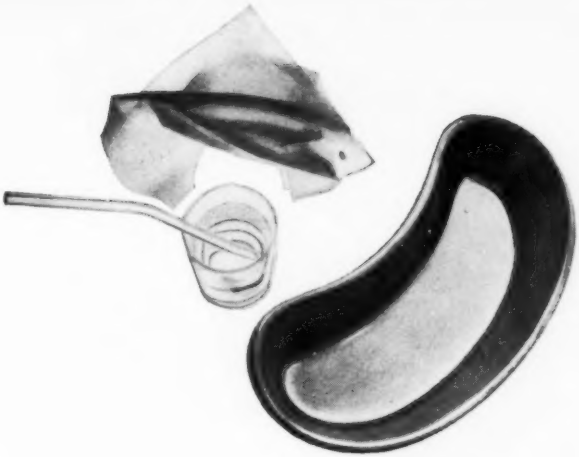
Other cases of overfondness have somewhat different causes. Let me illustrate one of them with an example:

Stranger's Approach

One day, a woman who had seen me professionally only a few times suddenly became much too effusive. I was by all odds the kindest, the most reliable doctor in the country, she said. Clearly, it embarrassed her to put this sort of thing into words. But she seemed sincere.

What would you have done in my place?

My first impulse was to brush



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1. Mathews et al.: Am. Pract. & Dig. Treat. 6:360 (Mar.) 1955.
2. Albert and Coakley: Anesth. & Analg. 33:285 (July-Aug.) 1955.

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off the compliment or to make light of it, so I could get on to a safer topic. You see, *I* was as embarrassed as she was. But the woman had spoken so seriously I couldn't ignore the compliment that had obviously cost her some effort to make.

The Hidden Cause

At this point, science rescued me. I knew that where there's an effect there must be a cause. And since the cause didn't lie with me, it must lie with her. My guess was that she felt guilty and anxious about something; and in order to tell me about it she had to believe that I, above all other medical men, was worthy of her trust.

She Told All

So I told her this. I said I felt sure she had something important to reveal, something she was holding back because it was too painful for her to talk about.

It turned out that I was right. Before her marriage, she said, she'd undergone an abortion. She'd never told anyone, and the guilt feeling was weighing heavily on her. She was glad she could tell me. [MORE ▶


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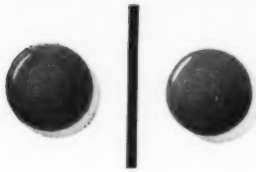

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It was evident to me that she hadn't been able to speak until she had established *in her own mind* that I was worthy of her secret. Her gushing words of affection had been the result of this need.

Preoperative Sign

Very commonly before surgery a patient will do the same thing. He *must* do it. He must build up the doctor in his own eyes before he can place himself in the doctor's hands.

As long as the physician realizes that a patient's evident affection for him is largely an expression of a problem the patient has brought to the doctor, the doctor-patient relationship isn't threatened.

If the physician keeps his head and understands what's going on, he should have little difficulty in dealing with the patient's openly expressed attachment.

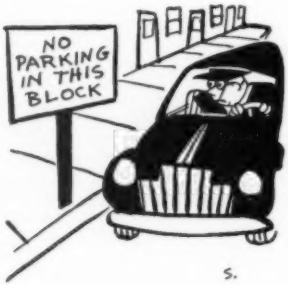
But the matter is complicated when, as sometimes happens, the attraction is overtly sexual. It goes without saying that it's tough to practice scientific medicine when *you're* concentrating on illness and the *patient* on love. What are you supposed to do?

If you try to go on with the case, you may be letting yourself in for anything from a broken marriage to a malpractice suit. If, on the other hand, you run away from the patient, you may be casting off a person who's dangerously ill.

How to Stop It

The best thing, of course, is to nip amorous overtures in the bud by being strictly professional—or even businesslike. But such detachment is apparently easier for some doctors than for others. Some even find it impossible to differentiate between a warm, friendly, professional regard for a patient and a warm, personal, not-so-professional regard.

It's interesting to note that many medical men are never troubled with romantically inclined patients, while others run



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into these situations all the time. I suspect that some doctors tend, by what they say or do, to suggest to susceptible patients that "Barkis is willin'."

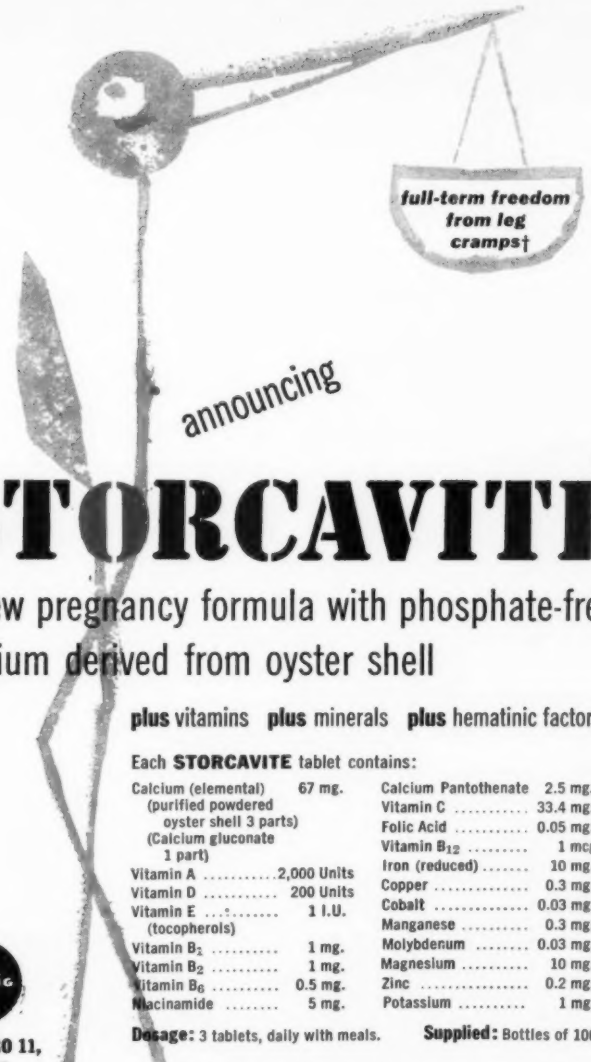
However, no doctor is immune. Anyone can become the object of attempted seduction. And unless he watches himself, the physician may easily be taken in by it. He may be tempted, for instance, to believe that the patient has found him irresistible and has fallen truly in love with him.

The facts are quite different. The patient who tries to seduce the doctor is neurotically *hostile*, not loving. A seductive advance is her way of trying to destroy the doctor as a doctor. It is an effort to knock him off his pedestal and to make him look cheap and ridiculous.

A Doctor Destroyed

And if the seduction succeeds, as sometimes happens, the patient actually does destroy the doctor's effectiveness. As far as she's concerned, he's now no longer doctor but lover.

So what do you do if, despite all efforts to dash cold water on



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the patient who's bent on making love, you find yourself being propositioned?

I know that some doctors use such devices as leaving the office, ringing for the nurse, or making light of the situation. That may be all right. But I prefer the direct approach.

'Emotions Excited'

I'd tell the patient that her emotions have been excited by her illness and by my treatment of it. I'd add something to the effect that I fully understand matters of this sort, and that I don't misconstrue her open declaration of love.

Then I would remind the patient—clearly and without any ifs, ands or buts—that the relationship is professional and that that's the way it's going to stay.

Is It You?

Sometimes this direct approach works wonders. At other times the patient persists. If one of yours does, my only suggestion is: Consult a colleague, if possible a psychiatrist.

Sometimes, of course, nothing you do works out the way it should. I recall one case in which a physician seemingly did everything right. Yet he got into trouble.

He tried honestly to keep his patient's mind on treatment. When that failed and, in unmistakable terms, she invited him to her apartment, he still did what seemed to be the right thing. He declined, pointing out that his relationship with her was purely professional.

As usually happens, the patient reacted angrily. The doctor didn't like her, she cried; he thought he was too good for her.

Wrong Way Out

The physician, a kindly fellow, didn't want the patient to go away mad. So he tried to reassure her. "Oh, no," he said. "It's just that I'm your *doctor*. If I weren't, maybe things could be different."

A good way to get out of a tough spot? No, indeed! A day or two later, the woman formally withdrew as his patient and went to another doctor. Then she called the first physician and said: "Now you're *not* my doctor, and I want to see you socially."

As I said before, if an overly affectionate patient persists in making advances, perhaps you'd better see a psychiatrist. END

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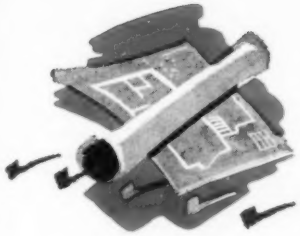

Is Remodeling Worth the Trouble?

This physician transformed an old house into a new medical office. What his experience taught him may well be of interest to you

By Rudolf A. Colmers, M.D.

You can buy an old house and remodel it for office use for much less than the cost of a new medical building of comparable size. All it takes is imagination, careful planning, and about a thousand hours of your spare time.

I found this out last year when I converted the first floor of a seventy-five-year-old multiple dwelling into a medical office.

For several years, I'd been practicing internal medicine in cramped quarters on the ground floor of a large apartment building in Stamford, Conn. Early in 1955, the landlord announced that when I renewed my lease, my rent would be raised considerably. That's when I decided I'd had enough. I needed more space; and I felt the time had come to get it on my own terms.

That decision raised the first of many problems that I had to grapple with during the next few months. Here's a

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OBJECTIVE AND SUBJECTIVE RESPONSE—Orally effective, Nilevar therapy is characterized by retention of nitrogen, potassium, phosphorus and other electrolytes in ratios indicative of protein anabolism. Moreover, subjectively the patient observes an increase in appetite and sense of well-being.

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WELL TOLERATED—Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently. Slight androgenicity may be evidenced on high dosage or in particularly responsive individuals.

MAJOR INDICATIONS—Preparation for and recovery from surgery; supportive treatment of serious illnesses (pneumonia, poliomyelitis, carcinomatosis, tuberculosis); recovery from severe trauma and burns; decubitus ulcers; care of premature infants.

DOSAGE—The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the average daily dose is 1 to 1.5 mg. per kilogram of body weight; individual dosages depend on need and response to therapy.

SUPPLY—Nilevar is available in uncoated, unscored tablets of 10 mg. G. D. Searle & Co., Research in the Service of Medicine.

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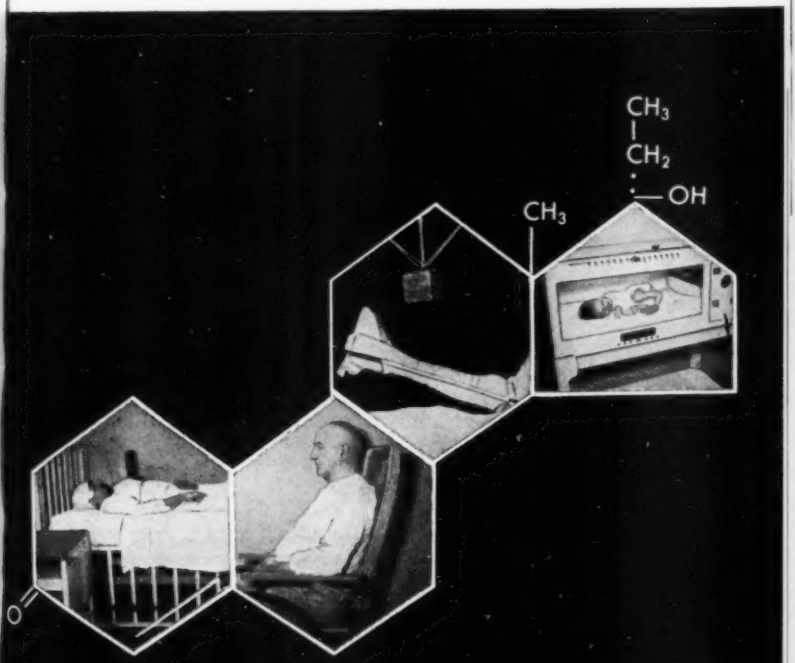

list of the major ones, along with an account of how I solved each one of them:

Should I go all out on a new building, or should I try to economize by buying an old place and remodeling it?

A new building, designed to my specifications, would of course have been preferable: It's never possible to get *exactly* what you want in a remodeled layout. And a friend of mine who's a contractor pointed out some additional drawbacks to the remodeling idea:

About half what I'd spend for remodeling would go toward tearing out existing structures—and would thus add nothing to the value of the building. Then, too, there was always the chance I'd find major flaws, hidden until the framework was laid bare, in any building I bought. And I'd have to spend far more than I'd bargained for on remedying such flaws.

Luck Plays a Part

Still, if I chose the building wisely and had a normal share of luck, I'd probably do all right. "It's my guess," added my con-

BETTER

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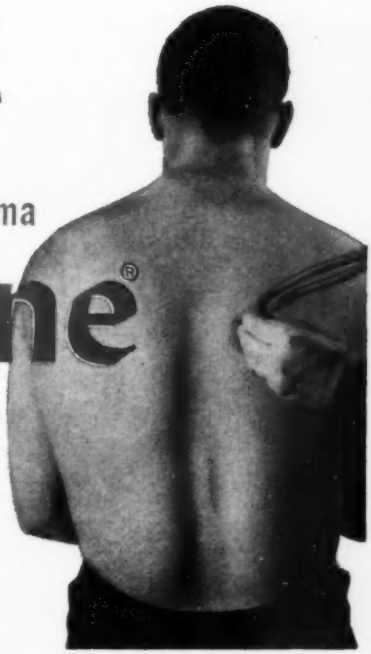

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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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tractor friend, "that your remodeled office should cost you only about two-thirds as much as a new one."

He Decided to Buy

A glance at my bank balance decided me. I began looking around for a suitable building to buy.

What is a suitable building for remodeling purposes?

The best location, I felt, would be in a well-kept-up residential area that was zoned for professional but not business use. And it was in just such a neighborhood that I at last found what seemed the right building.

It was a three-story house with an apartment on each floor. The first floor had just about the right amount of space—850 square feet—for the office I had in mind. And there were no architectural monstrosities, no unusable cubbyholes.

Bargain Price

The price of the house was reasonable, since the plumbing fixtures were vintage 1900 and the rooms hadn't been redecorated for years. But the building was by

no means in bad shape. And its two upstairs apartments were perfectly respectable. They would, I felt sure, be a dependable source of income, even if I left them just as they were.

Check-Up Needed

I didn't sign on the dotted line until my contractor friend had checked the structure carefully. He found the roof and heating plant in pretty good condition. There were no leaks, no sagging floors, no badly cracked plaster, no evidence of termites. In short, the chances were good that I wouldn't have to spend a king's ransom for fixing up the place. So I bought it.

Who's to do the remodeling work?

If I'd wanted to add a wing or to make big structural changes, I'd have been wise to engage an architect. On the other hand, if the contemplated job had required only a little plastering and painting, I might have hired workmen and supervised them myself.

But the changes I had in mind fell somewhere in between. So I needed a contractor. Naturally,

I asked my friend to take on the job.

I didn't insist on a written contract, since I knew the builder so well. But, generally speaking, I wouldn't advise others to follow my example. It's always a good idea to have costs, responsibility, and deadlines down in black and white.*

The contractor took care of such details as the building permit, inspection, workmen's compensation and public liability insurance. Of course he hired and supervised all the construction workers. And he also provided the necessary equipment and building materials.

I was made responsible for only one matter in this sphere:

Time vs. Money

At the contractor's suggestion, my wife and I did our own shopping for lighting and laboratory fixtures. That way, we were sure to get exactly what I wanted. We also saved the cost of the time the builder would have had to devote to such chores.

How can I modify the existing

*For tips on building contracts, see "If You Hire a Contractor," November, 1953, MEDICAL ECONOMICS.

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1. Rehfuss, M. E.: Indigestion, Philadelphia, W. B. Saunders Co., 1943, p. 322.
2. Shaftel, H. E.: J. Am. Geriatrics Soc. *1*:549 (Aug.) 1953.

structure best—and most economically—to provide the kind of office I need?

The ground-floor apartment had five rooms, plus bath. I wanted eight rooms: a reception room, a consultation room, two examining rooms, X-ray and dark rooms, a laboratory, and a small office for my aide. (Also a lavatory, of course.) It would have been easy to fit them in by removing all inside walls—including those that helped support the upstairs floors. But even if it had been structurally feasible, this procedure would have cost a fortune.

Contractor's Advice

The contractor insisted that we must retain as many of the old walls as possible, and he drew up a floor plan with this in mind. His plan was valuable, since it indicated what *sort* of changes would be feasible. But I couldn't accept it in toto because of some of its details. For instance:

My X-ray machine wouldn't fit into the proposed X-ray room. No dark room was provided. The consultation room was larger than necessary. The aide's office seemed over-full of waste space. The laboratory was too small and no outside ventilation had been planned for it.

"I guess nobody but a doctor really understands what a doctor needs," I said to my wife. "Where's a pencil and a piece of paper?"

No Draftsman He

Several sketches later, I realized that even a man who knows exactly what he wants may have a hell of a time figuring out how to get it. Drawing and redrawing floor plans is a hard, slow job. Whenever you get one corner right, the opposite corner invariably seems to go wrong.

Luckily, a friend to whom I mentioned the problem had the answer for me. "Why don't you try a floor-planning kit?" he suggested. "Lots of businesses use them in planning office layouts. They're a great help to anyone who hasn't had training as a draftsman."

Local Product

Several companies make such office-planning aids. I bought mine from a concern right in Stamford. The equipment consists of a plastic sheet, 24″ x 18″, marked off in quarter-inch grids, and of several bits of self-adher-

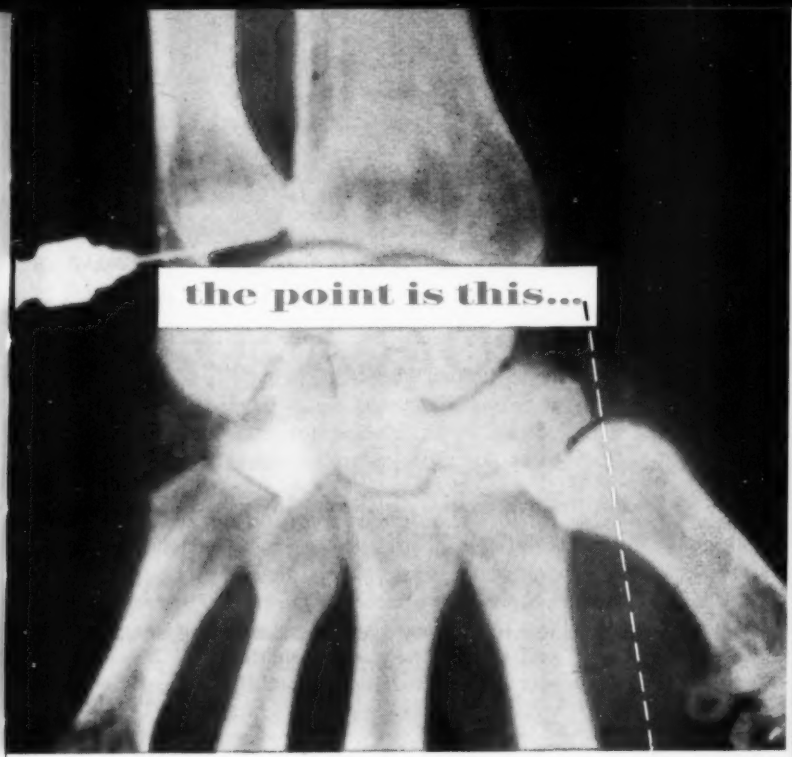
ing tape in various widths and colors. The tape can be laid out on the sheet to indicate walls, doors, windows, and other structural features, and any piece of it can easily be pulled up and shifted about.

In addition, there are small pieces of gummed paper cut to scale to indicate chairs, desks, cabinets, etc. These too can be moved around as often as you like.

The whole set cost me less than $10. With it, I soon devised a floor plan that was suited to my needs, yet that kept the walls my builder felt were essential.

A few walls *were* taken out and some extra partitions had to be added. But almost no other structural changes were neces-

"To the United X-Ray Corporation . . . Gentlemen: Your advertisement about your 1956 X-ray unit interests me very much. Please send me a sample for my personal use. Sincerely yours, etc., etc. . . ."



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References: 1. Hollander, J.L., *Ann. New York Acad. Sc.* **61**:511, May 27, 1955. 2. Hollander, J. L., *et. al. J.A.M.A.* **158**: 476, June 11, 1955.

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'Thora-Dex' is indicated in a wide variety of mental and emotional disturbances in which anxiety, agitation, or apprehension is complicated by depression.

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'Thora-Dex' is of value in many somatic conditions, apparently unrelated, but in which emotional stress is a complicating or even a causative factor. With tension, apprehension, anxiety and depression allayed, the clinical picture and prognosis are greatly improved.

When 'Thorazine' alone causes undesired drowsiness:

'Thorazine' alone sometimes causes drowsiness: while this effect may be desirable in some patients, it may prove troublesome in others. For instance, in the treatment of nausea and vomiting, especially in ambulatory cases where drowsiness is a problem, 'Thora-Dex' will be found widely useful. The patient treated with 'Thora-Dex' is generally more alert and assured, with normal interest, activity and capacity for work.

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'Thora-Dex' Tablets are available in two strengths: No. 1—'Thorazine' (chlorpromazine hydrochloride, S.K.F.), 10 mg., and 'Dexedrine' (dextro-amphetamine sulfate, S.K.F.), 2 mg.; No. 2—'Thorazine', 25 mg., and 'Dexedrine', 5 mg.

'Thora-Dex' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature on 'Thorazine'.

Smith, Kline & French Laboratories, Philadelphia

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‡T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

'THORA-DEX'

sary. The ceilings, for example, were low enough so that they didn't have to be dropped in order to improve the proportions of the smaller rooms. They required only a new coat of paint.

New Doors and Windows

As you'd expect, none of the doors and windows fitted tightly. So I had the old frames removed, then installed all new windows and slab doors. (The latter were the only sound-proofing devices required in this fundamentally well-constructed house.)

The old wooden floors needed no patching up or replacement. I simply had them covered with asphalt tile everywhere but in the laboratory (which has chemical-resistant vinyl tile) and the consultation and reception rooms (which are carpeted).

Finally, as a support for the extra load on the X-ray room floor, a couple of extra steel columns had to be installed in the basement.

Patch or Replace?

Should the building be completely rewired, even though the old wiring might still be usable?

Like most old houses, mine had barely enough circuits for domestic use, let alone the extra-heavy requirements of a medical

office. We'd have had to add a number of circuits, and we'd probably have had to patch up the original wires in several places. So I decided to install a complete new wiring system.

Obviously, this cost money. But it provided a safer and more satisfactory installation that won't soon need repairs, whether in my office or in the upstairs apartments. What's more, it permitted me to do certain things that are conveniently done only when the wiring job is started from scratch.

For example, I asked the electrician to run three separate circuits into the laboratory. Thus there's little danger that a fuse may blow when my centrifuge, sterilizer, and other appliances are all going at once.

I also had extra wall outlets installed in every room. These cost only about $4 each at remodeling time; I'd have to pay twice that if I wanted to add one now.

Because of the heavy electrical load in the building, I had to put in a new, 200-ampere service. This, I'm told, can handle any possible future load, including a second X-ray machine.

One Oversight

My only serious oversight in this area: While the power company's men were working in the building, I neglected to have them install separate meters for the apartments upstairs. So there's only one meter—as a result of which I must pay the electric bills for the whole house at a high commercial rate.

What's the best way to put in extra plumbing?

I needed five sinks in place of the two old ones (one in the kitchen, one in the bathroom). To get what I wanted, we *could* have run more pipes off the existing lines. But that might have given me only a trickle of water at each outlet.

Besides, brown stains in the water showed that the tubing had begun to corrode. So I installed new copper pipes. My decision

Lift the depressed patient up to normal without fear of overstimulation . . .

with new

Ritalin

A HAPPY MEDIUM IN PSYCHOMOTOR STIMULATION

• *Boosts the spirits, relieves physical fatigue and mental depression . . . yet has no appreciable effect on blood pressure, pulse rate or appetite.*

Ritalin is a mild, safer central-nervous-system stimulant which gently improves mood, relieves psychogenic fatigue "without let-down or jitters . . ."[1] and counteracts oversedation caused by barbiturates, chlorpromazine, rauwolfia, and antihistamines.

Ritalin is "a more effective and less over-reactive drug than amphetamine or its derivatives."[2] It does not produce the "palpitation, nervousness, jitteriness, or undue pressure in the chest area . . . so frequently mentioned by patients on [dextro-amphetamine sulfate]."[3]

Dosage: 5 to 20 mg. b.i.d. or t.i.d., adjusted to the individual.

RITALIN® hydrochloride (methyl-phenidylacetate hydrochloride CIBA)

References: 1. Pocock, D. G.: Personal communication. 2. Harding, C. W.: Personal communication. 3. Hollander, W. M.: Personal communication.

Supplied: Tablets, 5 mg. (yellow) and 10 mg. (blue); bottles of 100, 500 and 1000. Tablets, 20 mg. (peach-colored); bottles of 100 and 1000.

2/2193M

CIBA
SUMMIT, N.J.

to do so will surely save me trouble and expense in the future.

All the old plumbing fixtures had to be torn out, since I was converting the kitchen into a consultation room and the bathroom into an examining room. The sinks, toilet, and bathtub were not worth salvaging. I bought all new fixtures for the lavatory, examining rooms, laboratory, and dark room.

Heating Changes

What about necessary revisions in the heating system?

The oil burner and heating pipes didn't have to be replaced. But additional heating fixtures were needed in places where I'd divided one big room into two or three smaller ones. Since floor space was at a premium, I decided to do away with radiators and to install baseboard heating throughout. In this way I gained some thirty square feet.

A central air-conditioning system couldn't readily be added to a hot-water heating system like mine. So I plan to buy room air conditioners later on.

How long will the remodeling take?

It took me six months to find a house and to plan the remodeling. When actual work started, it took eight weeks. During those weeks, either my wife or I visited the place at least twice a day. In addition, we spent hours on the telephone making sure of deliveries and installations.

What about financing a remodeling project of this sort?

I bought the house itself for a modest amount and took out a mortgage to pay for it. The remodeling job cost a total of $10,500. To cover this expense, my bank lent me a total of $10,000 (in installments, as remodeling bills came due) at 5 per cent interest. Every three months, I make payments on interest and principal and renew the note, which I plan to retire in seven and a half years.

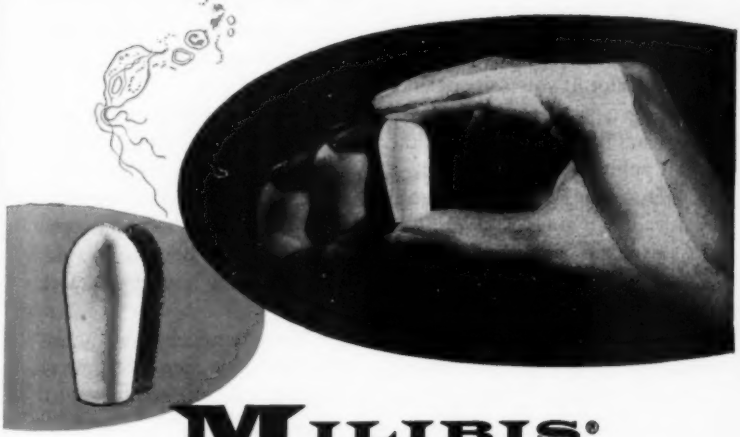
Special Bank Account

To keep my records straight for tax and bookkeeping purposes, I opened a special building account at the bank. The only checks I drew on this account were to cover the remodeling bills as they came due.

Though a remodeled building usually costs something less than a new one, it still isn't cheap. But mine has a good deal of rental space. The income during the

New Effectiveness

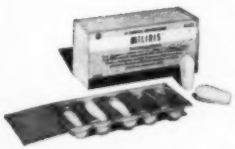
...for VAGINITIS:



MILIBIS®

Vaginal Suppositories

–soft and pliant as a tampon–white, odorless, non-staining–the suppositories bring new ease and new effectiveness to treatment of vaginitis.



SUPPLIED: BOXES OF 10

ELIMINATE SMEAR EXAMINATIONS*

Milibis vaginal suppositories are effective in trichomonad, Candida (monilia) as well as mixed and bacterial infections–thus laboratory identification of the offending organism is unnecessary.

THERAPEUTIC REGIMEN IS SHORT AND SIMPLE

A total of only 10 suppositories (one inserted every other night) has given a remarkable rate of cure of over 90 per cent in two large series of cases. Milibis vaginal suppositories are easily inserted high into the vagina and form a tenacious film which coats the cervix and rugae, killing pathogens on contact. Non-staining, well tolerated.

*Except when gonorrheal infection is suspected.

Winthrop LABORATORIES • New York 18, N.Y.

Milibis (brand of glycobiarsol), trademark reg. U.S. Pat. Off.

next few years should pretty well cover remodeling and maintenance costs.

As I think back over my experience, I realize that I've learned a lot. If you ever consider tackling a similar project, here are what now seem to me the chief points to keep in mind:

¶ Don't buy a building until you've had it gone over carefully by an expert—and until you've checked with the local planning and zoning boards.

¶ Plan every detail of the remodeling job in advance. Changes on paper cost nothing; but changes in wood, brick, and plaster—oh, brother!

¶ Don't get carried away. It's rarely a good idea to spend more than the original purchase price in remodeling.

¶ What you do, do well. You'll have to pay those hourly union wages—one of the biggest items in the remodeling bill—no matter what grade of materials you buy. So get the best. If you do, you'll save on later patchwork repairs.

¶ Don't remodel at all unless you can devote *plenty* of time to planning and supervision. END

Functional G. I. disorders resulting from tension and stress

Nervous stomach
Heartburn
Irritable bowel

Bellergal®

Average Dose:
3-4 Tablets Daily

Proven safe
in more than
3400 Published Cases

Ergotamine tartrate	0.3 mg.
Bellafoline	0.1 mg.
Phenobarbital	20.0 mg.

SANDOZ

Sandoz
PHARMACEUTICALS
HANOVER, N. J.

Showdown on Hospital Accreditation

[CONTINUED FROM 140]

commission's requirements. So they fall prey to other doctors who misrepresent those requirements.

"Doctors on the staffs of large hospitals complain that the meeting requirements are unrealistic. 'There's no auditorium large enough to hold our entire staff!' one says indignantly. Yet I know of one West Coast hospital that has probably never had a meeting of its whole staff in all its history. The Joint Commission doesn't require it."

While he concedes that the commission's bulletins don't always explain the requirements fully, Dr. Truman says that its official "Standards for Hospital Accreditation" do. He quotes them as follows on the subject of staff meetings:

"In very large hospitals where attendance requirements are obviously met by departmental meetings and where physical facilities are not available for large audiences, the commission may accept departmental meetings in

clinical advantages with

TETRACYN®

BRAND OF TETRACYCLINE

- rapid absorption and distribution to all parts of the body
- prompt, broad-spectrum action against infections caused by gram-positive and gram-negative bacteria, spirochetes, certain large viruses and protozoa
- minimal incidence of adverse reactions
- available in a wide selection of convenient dosage forms for oral, parenteral or topical use, including new *faster-acting, better-tasting* **TETRABON*** (brand of tetracycline) *homogenized mixture* 125 mg. tetracycline in each delicious, fruit-flavored 5 cc. teaspoonful; therapeutic blood levels within one hour. Bottles of 2 fl. oz. and 1 pint, packaged ready to use.

Tetracycline the nucleus of modern broad-spectrum activity discovered and identified by Pfizer scientists

*Trademark

Pfizer

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N. Y.

lieu of meetings of the entire medical staff."

Criticism of the commission can often be traced back to doctors who don't *want* to maintain reasonable standards, several commission members say. And Dr. Truman cites this case in point:

G.P.s Complain

"In Michigan, there's a forty-bed hospital that our inspectors recently refused to accredit. We on the commission unanimously upheld them. Within two weeks of our decision, I received a letter signed by half-a-dozen G.P.s complaining that it was absurd to try to make general practitioners live up to the standards of a university hospital.

"I was distressed that the G.P.s were apparently being blamed for the hospital's failure to be accredited. So I wrote to the board chairman, the hospital administrator, the chief of staff, and the G.P.s themselves. I told them I was astounded that they

hadn't *all* got together to improve their hospital.

"Neither the doctors nor the hospital administrator answered my letter. But I did hear from the board chairman. This is what he told me: 'For years we've been trying to require adequate records; for years we've been trying to appoint a tissue committee. But on both these efforts, we've been blocked by the very men who wrote to you. So don't be bothered by what they said. This is the most wonderful thing that's ever happened to our hospital.' "

'Just Isn't So'

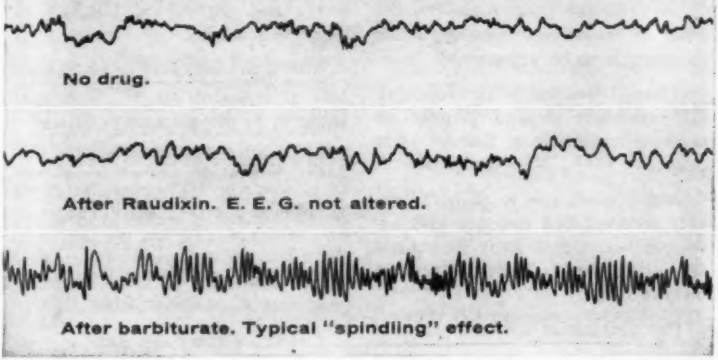
As for the complaint that the Joint Commission is harder on the medical staff than on the hospital administration, Dr. Kenneth Babcock, the commission's director, says, "This just isn't so. The commission would, I'm sure, flatly refuse accreditation to any hospital where nurses' aides were pouring ether."

("Such a practice could not be detected by the inspector," adds one of the commissioners, "unless it was noted in the patient's record. Hence the need for adequate records.")

Dr. Babcock also states that while doctors in a number of hospitals may occasionally code patients' diseases and operative

WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

Comparison of the effect of Raudixin (tranquilizer) and a barbiturate (sedative) on the cortical electroencephalogram



Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

Raudixin acts in the area of the midbrain and diencephalon, and does not depress the cerebral cortex. Consequently, the tranquilizing (ataractic) effect achieved is generally free of loss of alertness.

RAUDIXIN

Squibb Whole Root Rauwolfia Serpentina

DOSAGE: 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. per day.

SUPPLY: 50 mg. and 100 mg. tablets; bottles of 100, 1000 and 5000.

SQUIBB *Squibb Quality—the Priceless Ingredient*

"RAUDIXIN"® IS A SQUIBB TRADEMARK

Combined estrogen and androgen therapy provides a simple method for relief of postpartum breast engorgement

Osteoporosis also responds to dual steroid therapy

COMBINED estrogen and androgen therapy has been clinically confirmed to be more desirable than either hormone used alone for the relief of breast engorgement, when lactation is to be suppressed.

Optimal results with opposing sex hormones depend largely on prompt institution of therapy after delivery.

Osteoporosis, too, responds favorably to combined estrogen and androgen because of their synergistic anabolic action on bone and protein metabolism.

The rationale of sex hormone therapy for the relief of postpartum breast engorgement when lactation is to be suppressed has been explained as follows: during pregnancy, the high estrogen titer exerts an inhibitory effect on the anterior pituitary, thereby preventing the release of the lactogenic hormone, prolactin. Postpartum, the estrogen level drops off suddenly, and thus allows the release of the previously inhibited prolactin which is now free to initiate the flow of milk. Sex hormones, if administered promptly after delivery, reestablish the prolactin inhibiting titer, thus arresting the lactating process.

Estrogen alone may be unsatisfactory because the large amounts often required for effective action tend to induce marked endometrial proliferation with nausea, vomiting, excessive lochia and withdrawal bleeding as frequent side effects.[1,2]

Androgen alone may be unsatisfactory as extended use of testosterone tends to promote masculinization.

Estrogen and androgen act together to inhibit the lactogenic hormone while their effects on sex-linked tissue are minimized. Hence, the combined sex hormone approach is a logical choice for relief of breast engorgement and suppression of lactation.

Clinical efficacy of dual steroids confirmed repeatedly. Typical is Fiskio's report[2] of 267 patients who were given estrogen-androgen therapy in the form of "Premarin" with Methyltestosterone. Postpartum breast engorgement was relieved and lactation suppressed in 96.2 per cent of the cases. Results were evaluated on 1) relief of engorgement; 2) permanent suppression of lactation; 3) absence of side effects.

Results	Number of Patients	Percentages
Excellent	166	62.4%
Good	91	33.8%
Fair	10	3.8%

Patients in whom results were classi-

(continued)

Combined Estrogen-Androgen Therapy More Effective Than Either Steroid Alone *(continued)*

fied as *excellent* experienced no breast engorgement or untoward symptoms. Those who showed a mild transitory fullness were considered to have had *good* results. Only 10 patients displayed moderate engorgement and slight lactorrhea. There were no failures reported and there was a gratifying absence of breast abscesses, nausea, vomiting, excessive lochia, withdrawal bleeding or virilization. This author stressed the importance of institution of therapy within 45 minutes of delivery time for assurance of best results.

Fiskio's comments are of interest: "Of notable importance, too, was the absence of mental depression in the puerperium. This was believed to be due to the combined effects of estrogen and androgen.

"In this series the success of 'Premarin' with Methyltestosterone . . . was most gratifying. Its use provided a simple scheme of therapy that was fully effective in 96.2 per cent of the cases."

Combined Estrogen-Androgen Therapy Also Effective in Osteoporosis

Osteoporosis, almost physiologic after the menopause,[3] arises from inadequate osteoblastic activity due to gonadal decline together with faulty protein metabolism of bone matrix. Because gonadal function declines more rapidly in women, they are more susceptible to osteoporosis than men.

"Premarin" with Methyltestosterone induces an early physiologic reconstitution of bone. Estrogen stimulates osteoblastic activity while androgen enhances protein anabolism. Side effects are minimized because of the opposing action of estrogen and androgen on sex-linked tissue.

RECOMMENDED DOSAGE

In postpartum breast engorgement (when lactation must be suppressed):

Short duration therapy (one week) — 3 tablets (yellow) every four hours for five doses; then 2 tablets daily for rest of week.

"Step-down" therapy (10 to 15 days) (Yellow tablets used in divided daily doses as noted) 1st day — 4 tablets; 2nd day — 3 tablets; 3rd day — 2 tablets; thereafter, 1 tablet daily for 10 to 15 days.

In osteoporosis: 2 or 3 tablets (yellow) daily. In the female, it is suggested that therapy be given in 21 day courses, interrupted by weekly rest periods between courses; continue schedule for 6 to 12 months. Subsequently, the patient may be maintained with cyclic therapy employing "Premarin" alone.

Supplied in two potencies: the *yellow* tablet contains 1.25 mg. of conjugated estrogens equine ("Premarin"®) and 10 mg. of methyltestosterone; the *red* tablet contains 0.625 mg. and 5 mg. respectively. Both potencies are available in bottles of 100 and 1,000 tablets.

BIBLIOGRAPHY: 1. Wilson, T. M.: M. Ann. District of Columbia *23*:489 (Sept.) 1954. • 2. Fiskio, P. W.: GP *11*:70 (May) 1955. • 3. Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, ed. 2, New York, The Blakiston Company, Inc., 1954, vol. 1, chap. 98, p. 700.

procedures, the commission does not require it.

Summing up the Joint Commission's reaction to criticism, one member says:

"Local people cannot assume real responsibility unless they have some national yardsticks. But if they'd read the standards, they'd realize that our yardsticks aren't at all unreasonable."

Umpire's Answer

Who's right—the commission's critics, or its apologists?

A year ago, the A.M.A. set up a seven-man committee, headed by Dr. Wendell C. Stover, to study the charges against the Joint Commission. At this writing, the Stover Committee's findings haven't yet been made public. But talks with committee members have made the gist of their findings clear.

Here they are in brief:

¶ *Some commission requirements have indeed been unreasonable.* "For example," says one member of the Stover Committee, "we don't believe that the Joint Commission should force an ophthalmologist to attend a meeting at which obstetri-

cal deaths are discussed. Nor do we believe that the commission should be concerned with whether or not a doctor signs hospital records in one place, five places, or ten."

Instead of concerning themselves with dotted i's and crossed t's, he adds, commission inspectors should concentrate on determining whether or not a hospital has good records. And he defines "good" records as those that are "sufficiently detailed and of high enough quality so that a physician could defend himself against a malpractice charge."

Summing up the Stover Committee's views on this point, its chairman says: "We believe the commission should establish general principles of sound hospital organization. But note this well: It should leave the specifics of implementing those principles in the hands of the local hospital staffs."

Special Interests

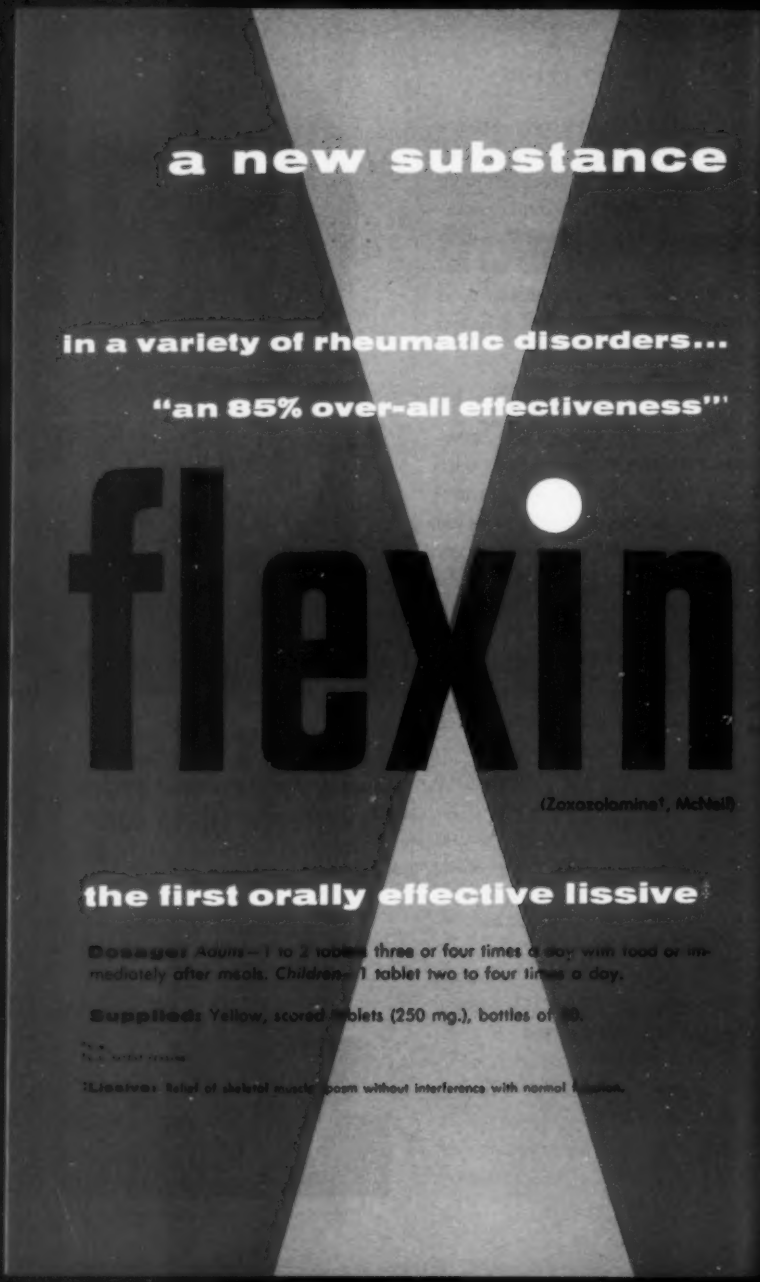
¶ *The commission needs its own inspectors—and it needs more of them.* "When the surveyor who comes to a hospital is on the payroll of the A.C.S. or

the A.H.A.," says one Stover Committee member, "naturally the doctors there feel they've been inspected by representatives of the surgeons or the hospital people. They end up believing that the commission is dominated by some special group."

Doctors Upheld

The Stover Committee concurs with the many doctors who believe that the Joint Commission should have its own salaried staff of inspectors. With a larger staff of its own, the commission would undoubtedly be able to do more inspecting, says the committee. (It cites complaints from many doctors that some hospitals have had to wait three years between surveys.)

¶ *The commission should do a far better job of explaining itself to doctors.* While it may be that the commission has made some unnecessary demands on hospitals, it's also true that it has received much unjustified criticism on this ground. Dr. Stover notes, for instance, that "the Joint Commission has never tried to grant privileges to one group of doctors and not to another. It has always said that privileges must be determined by the medical staff concerned." [MORE ▶


a new substance
in a variety of rheumatic disorders...
"an 85% over-all effectiveness"
flexin
(Zoxazolamine†, McNeil)
the first orally effective lissive
Dosage: Adults—1 to 2 tablets three or four times a day with food or immediately after meals. Children—1 tablet two to four times a day.
Supplied: Yellow, scored tablets (250 mg.), bottles of 50.
†Lissive: Relief of skeletal muscle spasm without interference with normal function.

"Take the matter of appealing a Joint Commission decision," says Dr. Stover. "Of course there's a method of appeal back to the commission. But probably it hasn't been sufficiently publicized. We're recommending that an outline of the appeal method go out to each hospital that gets an unfavorable commission report."

A.M.A. Help Sought

To help improve the commission's intraprofessional relations, the A.M.A. public relations department might well assist the Joint Commission, suggests Dr. Stover's committee. It recommends that both organizations work together on an informative program for doctors.

Dr. Stover capsules his committee's recommendations this way:

"We feel that some power must be taken away from the Joint Commission and given back to the hospitals. We believe, above all, that implementation of commission standards should be placed squarely in the hands of the hospitals. If this were done, the commission could again become what it was originally intended to be: a disinterested outsider which can judge whether its standards and principles have been put into practice reasonably well.

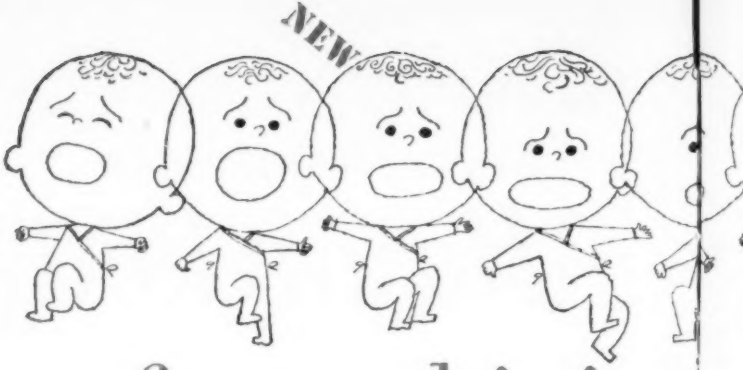
"We've also recommended, however, that the commission be given more power to control its own staff and more money to inspect hospitals. Thus it can better fulfill its functions."

Does the Stover report really get to the heart of the accreditation problem?

Last month, most doctors who had seen it seemed to believe that it did. The report had justifiably upheld some of the doctor's complaints, they pointed out; it had come up with sensible solutions. In addition, it had noted that the commission has sometimes been unfairly maligned by doctors.

Will Friction Subside?

"Let's remember that the Joint Commission is just a baby. It should be given a chance to improve," said one doctor. Most well-informed observers believe the Stover Committee report will increase the commission's chances for improvement. And a better job by the Joint Commission will be bound to reduce friction among doctors and their hospitals. END



from whining

NEW

BONADOXIN® DROPS

stop infantile colic...

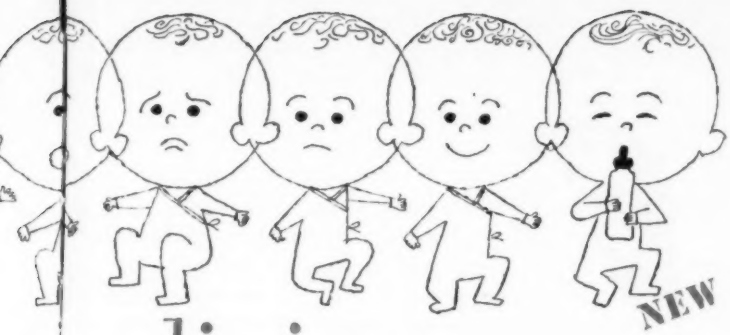
in hours

without barbiturates

without belladonna

ROERIG Chicago 11, Illinois

1. Dougan, H. T.: Bonadoxin Drops: an effective oral therapy for infant colic & pylorospasm. Journal-Lancet (May) 1956. In Press.



ngo dining

BONADOXIN DROPS attack the known mechanisms of infantile colic with

Antihistamine action: to relieve colic of possible allergic origin.

Anticholinergic activity: to break the cycle of emotional tension, smooth muscle spasm, pain.

Tranquilizing effect: to calm the infant and permit sleep.

B_6 prophylaxis: added protection against colic and infantile convulsive disorders due to pyridoxine deficiency.

NEW

Clinical studies. Bonadoxin Drops were effective in the therapy of infant colic and pylorospasm in 22 (88%) of 25 patients. Dramatic improvement was observed in some of them. There were no side effects, and complete tolerance and acceptance were observed in all infants. The authors were able to regulate dosages with great flexibility, adjusting them upward, in several instances, for better management of intestinal complaints. All children found the lime-flavored liquid agreeable. [1]

Confirm these results in your own practice; put BONADOXIN DROPS to work on the next six fussy babies you see.

Each cc. BONADOXIN DROPS contains:
Meclizine Dihydrochloride . 8.33 mg.
Pyridoxine Hydrochloride . 16.67 mg.

Dosage:	**Age**	**cc.**	**Drops**
	Birth-3 mos.	0.5 to 1.5 cc.	15-45 daily
	6 mos. to 2 yrs.	1.5 to 3.00 cc.	daily
	2-6 yrs.	2.00-4.00 cc.	daily
	older children	3.00-6.00 cc.	daily

Supplied in 30 cc. dropper bottles.

NEW *phosphorus-free prenatal supplement*

COMPREN

(PRENATAL DIETARY SUPPLEMENTS, LILLY)

helps meet the nutritional challenge of pregnancy

Important advantages for the well-being of your patients:

- *High calcium content*—There are 250 mg. of available calcium (as calcium carbonate) in each Pulvule 'Compren.'
- *More vitamin B_6*—Increased amounts of vitamin B_6 during pregnancy have been recommended by clinical investigators. Vitamin B_6 may also be helpful in nausea and vomiting of pregnancy.
- *Intrinsic factor*—All generally recognized vitamins, including intrinsic factor for optimal absorption of vitamin B_{12}, are present in 'Compren.'
- *Convenient low dosage*—Just one pulvule three times daily is adequate for the great majority of patients.

Each daily dose (3 pulvules) of 'Compren' provides:

Thiamine Mononitrate	1.5 mg.
Riboflavin	3 mg.
Vitamin B_{12} (Activity Equivalent) 7.5 mcg. plus sufficient Intrinsic Factor Concentrate to produce activity equivalent to that of 1/2 U.S.P. APA unit (oral)	
Ascorbic Acid	100 mg.
Nicotinamide	15 mg.
Folic Acid	0.4 mg.
Vitamin A Synthetic	6,000 U.S.P. units
Vitamin D Synthetic	400 U.S.P. units
Iron (as Ferrous Sulfate)	15 mg.
Pyridoxine Hydrochloride	6 mg.
Calcium Pantothenate (as Calcium Pantothenate, Racemic)	6 mg.
Calcium (as Calcium Carbonate)	750 mg.

In bottles of 100 and 500 at pharmacies everywhere

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608019

Could You Adapt To Group Practice?

[CONTINUED FROM 130]

physician in a group where the older men indulge their foibles or crotchets. One young fellow I know had to work with a surgeon notorious for his stinging remarks. After several months, he could stand it no longer. He went to the group's business manager and told him he was going to resign.

The business manager laughed when he heard the doctor's reason for quitting. "I assure you," he said, "that Dr. X talks like that to *everybody*. He always has. He always will. Just don't take it to heart and you'll get along fine."

That's exactly what happened. The junior man learned to disregard the surgeon's sharp tongue and to appreciate his technical skill. Today they're the closest associates in the group.

As a rule, the physician who develops close ties with his colleagues soon realizes that no individual in the group can function successfully without the help of the rest. Any man who doesn't appreciate this fact is pretty sure to discover that he's a misfit in combined practice.

A few years ago, an Oklahoma group took in the first new member it had accepted in some time. It paid him a decent salary and laid plans to make him a full partner.

The new doctor quickly developed a large practice and brought in a good deal of the group's income. But he also behaved as if he deserved all the credit. He asked for more money before the group even had a chance to vote him a larger share. And he berated some of the other doctors behind their backs because their practices weren't so large as his.

He'd forgotten that most of his practice had been built on referrals from the group members. He'd also forgotten the number of patients he owed to group prestige built up over the years.

The senior members decided to let him go. They needed a good man in his specialty—but not at the psychological price he was making them pay.

Goodwill *within* the group, I've concluded, breeds goodwill *toward* the group. Aim for the maximum of both and you'll get along in group practice. END

for immediate and prolonged relief of

HAY FEVER and SUMMER COLDS

DRILITOL*

'Drilitol' is dramatically effective in hay fever and summer colds because it provides complete 3-way therapy:

relieves local allergic manifestations—
antihistaminic **thenylpyramine hydrochloride**

rapidly opens blocked nasal airways—
the superior vasoconstrictor, **Paredrine† Hydrobromide**

combats bacterial invaders and curbs complications—
the synergistic action of anti-grampositive **gramicidin** and anti-gramnegative **polymyxin**

available in two forms:

'Drilitol Spraypak' and 'Drilitol' Solution

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.
†T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.
'Spraypak' Trademark

News

[CONTINUED FROM 29]

staff physicians agree to have their financial records audited.

When first considered for adoption at St. Joseph's last year, the Columbus plan was vigorously denounced by general practitioners. Nevertheless, St. Joseph's has now adopted the program; and it has also set up a unique schedule of maximum fees that can be paid to doctors assisting at operations.

Under the schedule, the most an assisting doctor can receive is $60. If the Blue Shield fee ranges between $100 and $150, he'll be paid $30. If it's less than $100, he won't get a penny. What's more, surgeons are prohibited from selecting referring physicians as their assistants.

Although Dr. Samuel Rosenthal, St. Joseph's chief of staff, denies that the plan is "discriminatory against any medical group," Milwaukee G.P.s are up in arms. Dr. Robert F. Purtell—not a member of St. Joseph's staff, but president-elect of the Wisconsin Academy of General Practice—calls it "a disgraceful insult" to the integrity of all doctors.

The Milwaukee chapter of the A.A.G.P. argues that the plan won't actually prevent fee splitting. Instead, it claims, the program will jeopardize Blue Shield. None the less, the organization has advised St. Joseph's general practitioners to sign the agreement "because of the current hospital bed shortage and [our] concern for general patient welfare."

What Your Office Aide Should Know

Does your aide know what K.U.B. and U.C.H.D. stand for? Or how to stop payment on a check? Or how to administer one-third of a drop of medicine?

If not, she'll be able to find the answers to these problems in an authoritative new book, "The Office Assistant," by Portia Frederick and Carol Towner.

The 351-page volume, just published by W. B. Saunders Company, Philadelphia, has twenty-six chapters covering every phase of the aide's work.

Each of the topics is discussed in considerable detail. For example, there are step-by-step instructions for preparing a patient for chest, abdominal, pelvic, rectal, EENT, and complete physical examinations. And there are exhaustive discussions of such matters as bookkeeping, filing, and telephone techniques.

In addition to help on the usual (and not-so-usual) duties of a medical office aide, the authors have provided background information that will help explain to


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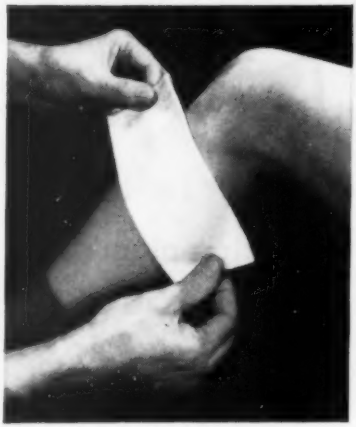
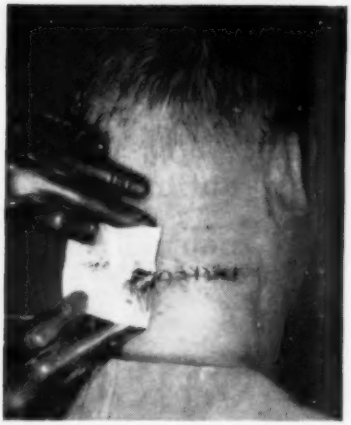


TELFA Strip is ideal for minor wounds, burns and plastic cases. Easy-to apply. Doesn't hurt or tear the scab when you take it off. Convenient sizes—and they can be cut to fit any wound, without raveling.



Note easy and painless removal of TELFA dressing on 6th day after excision of neck tumor. The healing tissue and stitches are undisturbed, no sign of irritation. Wound is dry and healing is well advanced.

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This means that you can now employ the advanced TELFA *technique throughout your dressings practice. And save up to 41% on dressings costs.*

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Result: you get fast, *primary* healing . . . as well as less patient discomfort.

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your girl why *you* do some things as you do.

She'll learn, for instance, what precautions you must take to avoid malpractice charges, why you sometimes make a patch test, and why you're interested in the activities of professional and health organizations.

High Fees Don't Pay, Chiropractor Finds

For a while, it appeared that Carl C. Lee of Sacramento, Calif., had discovered a way to practice medicine (or chiropractor's facsimile thereof) with minimum overhead and maximum returns. Then suddenly the roof fell in on him.

In 1950, it seems, Lee treated a jaundice patient with a daily cup of herb tea. The regimen lasted five months—and cost the victim $46,971. That same year, Lee gave a car salesman several "small bottles of dark fluid." Cost of the therapy: $26,000. Another of Lee's patients was offered a $32,500 course of treatment guaranteed to add twenty years to her life. The woman wasn't quite that well off, so she took the chiropractor's short course instead. It set her back $6,000.

All this came to light recently when the U.S. Government took the chiropractor to court on charges of evading more than $26,000 in income taxes in 1950 alone.

After many of his former patients had testified against him, Chiropractor Lee was found guilty, fined $10,000, and sentenced to five years in prison.

He's appealing.

Military Doctors Due For Pay Increases

One reason why the doctor draft may soon become unnecessary: A recently passed law has boosted the pay scale of military doctors.

The Department of Defense, which helped to push the legislation through Congress, figures that the pay rise will encourage many more young physicians to seek military careers.

A big drawback of the doctor draft, from the military point of view, has been that it resulted in too fast a turnover of medical-officer personnel. As Dr. Howard A. Rusk, head of the Government's Health Resources Advisory Committee, points out:

"During the past three years, over 13,500 physicians have entered military service under the impetus of the doctor draft. Of them, only 515 applied for and were granted commissions in the regular service, and in the same period 1,169 regulars resigned or otherwise left the service.

"Currently," adds Dr. Rusk, "less than one-third of all physicians in the service are regulars,

and this percentage has been decreasing steadily." To offset this trend, "the Armed Forces have established an objective of increasing the career medical and dental officer strength to two-thirds of their total needs."

Their chances of achieving such an objective appear somewhat brighter now that the disparity between military and civilian doctors' incomes has been reduced.

"In the past twenty-seven years," reports Dr. Rusk, "[the average net income of civilian physicians] has nearly tripled, but the income of the career military doctor [has] increased by less than 75 per cent. It is estimated that the average civilian physician had a net income of $16,500 last year, as compared to the annual net income of $9,201 for military doctors holding the rank of major or lieutenant commander."

Under the new plan, earnings of doctors in the Armed Forces will be boosted by a double concession to medical men: (1) They'll be given longevity credit for their years of medical schooling and interneship; and (2) they'll qualify, on completion of interneship, for promotion to a higher rank than the physician formerly got at that point in his career.

Here's how the plan narrows—though by no means closes— the gap between incomes of military and civilian doctors. The following figures are supplied by the Department of Defense:

Years of Professional Practice	Monthly Net Income		
	Current Military	Proposed Military	Private Practice
2	$577	$627	$1,000
6	624	724	1,000
10	720	870	1,280*
15	846	996	1,470*

Laymen Told How Doctors Keep in Shape

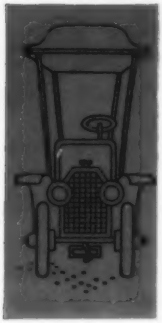
Why is it that you're seldom sick, even though as a physician you work irregular hours and often bolt your food?

"The secret seems to lie mostly in two words: rest and hobbies," Dr. Joseph D. Wassersug points out in Household magazine.

In addition to observing common-sense health rules, he says, the typical doctor does four things in order to stay well:

¶ *He learns to relax:* "All doctors know the value of sleep, perhaps because they get so little of it," says Dr. Wassersug. "Many a physician gets his 'forty winks' in early afternoon, just before office hours." He tells of a Boston surgeon, for example, whose work day often extends from 6:30 A.M. to 11:30 P.M. Reports the Bostonian: "Nearly every afternoon . . . I take

*General practice; monthly net income for specialists with ten years' professional practice is estimated at $1,400 and with fifteen years at $1,720.



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a one-hour rest . . . If it weren't for these afternoon naps, I don't think I could take it."

¶ *He goes fishing:* "Every physician that I know, *without exception,* is a disciple of Izaak Walton."

¶ *He has a hobby:* "For many doctors, fishing is a second profession, not a hobby in itself. So they find other ways of relaxing at home."

¶ *He gets married:* "In the town in which I practice," Dr. Wassersug observes, "there are 110 physicians. Only two of them are single. In any profession or trade, married men outlive and stay healthier than men who remain single."

Workmen's Compensation Benefits Increase

Workmen's compensation laws are now providing more liberal payments to workers and their dependents, as a result of amendments enacted by forty state and territorial legislatures last year. And, of course, the higher payments mean better—and surer—fees for doctors.

Among the more noteworthy of the legal changes, as summarized by Charles T. Houston of the U.S. Chamber of Commerce:

¶ In thirty-two of the states and territories, there's no longer any limit on the length of time during which surviving dependents may receive payments.

¶ Both Arizona and Colorado have "substantially increased medical care and compensation benefits for occupational diseases."

¶ "Hawaii [has] enacted a law providing for rehabilitation of injured workers . . . with a $1,000 maximum limit."

Fluoridation 'Expert' Loses a Fight

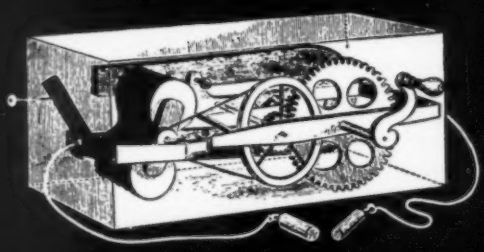
There are medical men who sincerely believe that fluoridation of public drinking water is dangerous. But fluoridation's most prominent opponents aren't doctors; they're self-styled "experts." One such "expert"—Miss Lillian Van deVere—recently received her comeuppance at the hands of West Hartford, Conn., when the town adopted fluoridation despite her determined fight against it.

Only a few years ago, Miss Van deVere almost single-handedly defeated fluoridation in Hartford proper. She did it by yelling "Rat poison!" until some city officials and civic leaders began to echo her words.

But since then, the Hartford area has been made healthily aware of what's behind Miss Van deVere's claims to medical knowledge. Among the publicly revealed facts that apparently helped defeat the woman's anti-fluoridation propaganda in West Hartford:

¶ Miss Van deVere claims to be

MAGNETO-ELECTRIC MACHINE



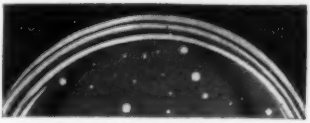
a "medical research assistant who has performed scientific medical research experiments at the [Columbia] College of Physicians and Surgeons." She also asserts she's done post-graduate work at Harvard. *But*, says the Hartford Courant, she took only two short courses in bacteriology at Columbia, neither of which would qualify her as an expert. She also took a two-week course in blood counts at a Boston hospital, which denies that the course was post-graduate study of any kind.

¶ She says she's had "laboratory experience as bacteriologist, serologist, biochemist, and assistant pathologist at state, municipal, and private research laboratories." *But* the Courant's study of her record showed only this: For fifteen months, back in 1941-42, she was employed by the Connecticut State Health Department as a temporary junior serologist and as a junior, assistant, and full-fledged microbiologist. Her various titles were the results of job reclassifications rather than of promotions. Her service ratings were "below average."

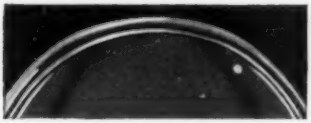
¶ Hardly pertinent scientifically, but none the less of interest, is the fact that Miss Van deVere once claimed she was a princess. At the time, she was married to a New Britain, Conn., dishwasher who was posing as a prince. Six months

DIAL SOAP with Hexachlorophene
effects 95% reduction in skin bacteria

Photomicrographs show why



With ordinary soap. Even after thorough washing, thousands of active bacteria remain on the skin.



With Dial soap. Daily use of Dial with Hexachlorophene eliminates up to 95% of resident skin bacteria.

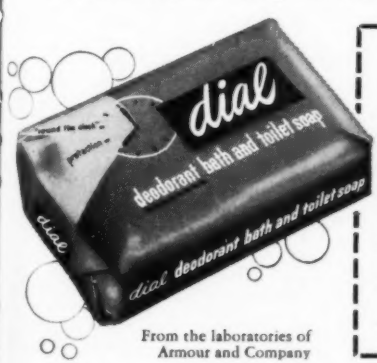
1. *Reduces chance of infection* following skin abrasions and scratches because Dial effectively reduces skin bacteria count.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known to be the chief cause of odor.

3. *Protects infants' skin,* helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers, rubber pants.

4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

You know, of course, the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first toilet soap to offer Hexachlorophene content to the public. You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Furthermore, Dial Soap is economical, and widely available to patients everywhere.



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after the couple were arrested for masquerading, they were taken into custody again. Both were charged with—and convicted of—theft.

Social Security Called 'Get Rich' Scheme

Doctors who dislike the whole idea of Social Security will find vivid expression of their views in some recent remarks by Clarence E. Manion, former dean of the Law School of Notre Dame:

He compares the Federal Social Security program to a fraudulent investment scheme perpetrated by a man named Charles Ponzi, back in 1920.

Ponzi claimed he could double anybody's money in ninety days, Dean Manion recalls. Eager investors heaped millions of dollars upon him during the first six months of 1920. And, surprisingly, the promised returns came back to them, often ahead of schedule.

Then, in August, the Government closed in on the financial magician. He protested that he'd paid all his clients, and that if left alone he would continue to do so. But he was jailed for fraud; and after serving eleven years of his term he was deported to his native Italy.

That isn't the end of the story, as Clarence Manion now tells it. "Ironically," he continues, "Ponzi was hardly out of the country before the same Federal Government that had imprisoned him for fraud proceeded to adopt the Ponzi 'get rich easy' scheme as its very own" —but with these two differences:

1. "Ponzi had to induce his customers to come in voluntarily; whereas the Government now *forces* 65 million workers to 'invest' $6 billion a year in its glorified version of the Ponzi scheme."

2. "Ponzi paid back at the annual rate of sixteen to one. The Federal Government does even better. Some of its very lucky participants are now drawing back at the rate of $100 for every dollar invested."

How is this "miracle" worked? Dean Manion answers the question by quoting the court that tried Charles Ponzi: " 'Ponzi's scheme was the old fraud of paying the early comers out of the contributions of later comers . . . It was another instance of robbing Peter to pay Paul.'

"The court did not know that the future Government Social Security system was to provide the most striking example of all," comments Clarence Manion. "The Chief Actuary of the Social Security system now says of it: 'The system is not fully funded in the sense that all benefit rights earned to date could be met by the existing assets if the program were to be liquidated' . . . In other words, the

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The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout[1] have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot[2] and his associates used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

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[1]Albertson, H. A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

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ACHROMYCIN ACHROMYCIN

official assumption is that there will always be more Peters to be robbed than there are Pauls presently to be paid."

Travelers Warned About European Racketeers

Going to Europe this summer? According to Government figures, more than 23,000 doctors have preceded you during the past three years. They and many other tourists have had to learn the hard way how easy it is to be "taken" by Europe's petty racketeers.

Now the European Travel Bureau—a private organization at 1740 K Street, N.W., in Washington, D.C.—has issued a comprehensive booklet describing the more common rackets. Among its tips for avoiding loss of face (and money):

¶ "Guard your passport almost as you would your life. There are those in Europe who will pay $1,000-plus for it in the black market." One of the trickiest confidence games concerning passports, says the booklet, is often worked at points of entry into a country: An "official" looking man approaches travelers and asks to see their passports; he's likely to get them—and run off with them, too—since he usually wears a visored cap with some sort of insignia on the front. "Do *not* give this man your passport," warns the bureau. "Upon entering a country, usually the only place you must show your passport is [at] the customs office inspection," which isn't hard to recognize.

¶ Beware of the moneychangers. "Three simple rules to beat them: 1. Notice the denomination of the bill you hand out for payment. 2. Recount your money after the other person has had his hands on it before pocketing it. 3. Never accept neatly folded bills without rechecking the amount on the spot."

¶ Learn the cost of your hotel room in advance. "Too often rooms will be quoted at one price, but when you check out the clerk starts adding the various incidental charges such as taxes, service charges, heat, bath, etc., and you'll end up paying about 80 per cent more than you agreed on initially. The extra charges are legal, however."

¶ Be careful of taxi drivers. Many "will take their tip out themselves before giving you your change . . . Insist on the correct change . . . When you get into a taxi be sure that the flag on the meter is pulled down at the start. Some drivers will 'forget' to do this, then stick you with a fare that's triple what it should be."

¶ Stay away from street vendors. One type of vendor "will try to sell you a fake Parker '51' for about one-fourth what the legitimate product costs in the U.S. A real saving, except the thing falls apart

shortly after you try using it. They are made in Italy and look exactly like the real thing. If you look closely, you will see that the name on [them] is 'P. Arker."

Specialty Group Prints Magazine for Patients

Something new in reception-room literature: a specialty journal published *by* doctors *for* patients. The American College of Radiology now puts out a highly readable quarterly.

Its sole purpose is betterment of public relations. To appeal to the lay reader, it presents facts about both radiology and medical economics in terms that the average patient can appreciate.

The first issue features a picture story on the training of a radiologist. It also contains articles on such subjects as "atomic cocktails" of radioactive iodine, mass X-ray screening programs, and methods of protection against radiation.

Opportunity Beckons In the Suburbs

Relocating? Don't overlook the suburbs of a large city as a likely spot for your new office. Many such areas are expected to do better than double in population during the next twenty years.

That's the conclusion of U.S. News & World Report economists, based on data supplied by local planning boards. Here's how the suburbs of a few selected cities are expected to grow by 1975:

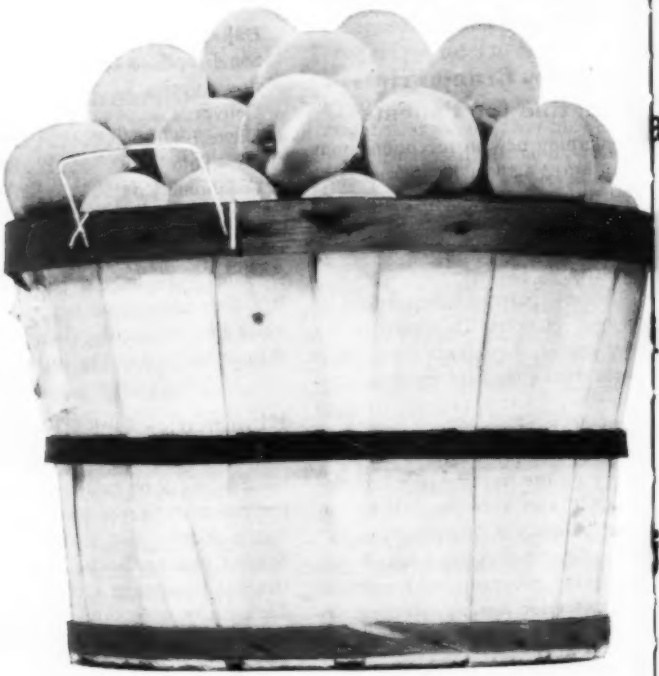
Dallas	191%
San Francisco-Oakland	171
Los Angeles	145
Denver	117
Dayton, Ohio	114
Cleveland	105
Oklahoma City	103
Portland, Ore.	100

Most of the nation's big cities are also expected to get bigger. But their anticipated expansion is much less spectacular than that of their suburbs, say the forecasters.

Rheumatics Get Break

Because high-priced drugs can become a crippling financial burden for rheumatic fever patients, one state's doctors and druggists have banded together to help ease the strain. Connecticut victims of the disease can now buy the needed drugs at a fraction of their normal cost.

The program is sponsored by the Connecticut Heart Association, the state medical society, and major pharmaceutical groups. Under it, doctors write out special prescriptions and pharmacists fill them without profit. Since last June, a total of more than 1,300 rheumatics have benefited from the arrangement. END



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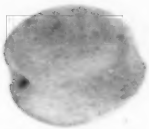

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Subject Index to

Medical Economics

January to June, 1956

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Antibiotic A	71.4	55.5	25.0	93.5	96.9	66.0	26.6
Dihydrostreptomycin	14.2	25.9	12.5	38.7	27.2	28.0	6.6
Antibiotic B	3.5	0	0	66.1	63.6	0	2.2
Penicillin	3.5	0	0	27.4	39.3	0	0
Antibiotic C	14.2	7.4	18.7	46.7	72.6	22.0	11.1

ADAPTED FROM PERRY[2]

Furadantin's "high degree of effectiveness against bacteria responsible for urinary tract infections is brought out by this study."[2]

Furadantin dosage—simple and safe: Average adult dose is 100 mg., q.i.d., (at mealtime, and on retiring, with food or milk). Average daily dosage for children is 5 to 7 mg./Kg. in four divided doses.

SUPPLIED: Tablets, 50 and 100 mg., bottles of 25 and 100.
Oral Suspension, 5 mg. per cc., bottle of 118 cc.

REFERENCES: 1. Waisbren, B. A., and Crowley, W.: A.M.A. Arch. Int. M. **95**:653, 1955. 2. Perry, R. E., Jr.: North Carolina M. J. **16**:567, 1955.

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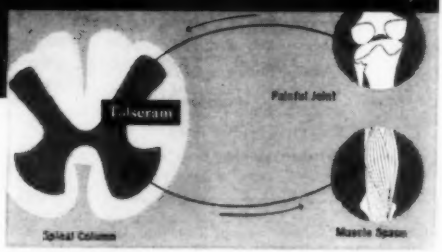
Tolseram

SQUIBB MEPHENESIN CARBAMATE



Through selective blocking action on the internuncial system, Tolseram tends to interrupt the spasm-pain-spasm cycle, relieving the discomfort of skeletal muscle spasm and frequently permitting increased range of motion.

Dosage: 2 to 6 Tablets, or 1 to 3 teaspoons Suspension, three to five times daily, after meals or with a glass of milk or orange juice.

Supply: Tablets, 0.5 Gm., bottles of 100 and 1000. Suspension, 1.0 Gm. per teaspoon (5 ml.), bottles of 1 pint and 1 gallon.

SQUIBB

TOLSERAM® IS A SQUIBB TRADEMARK

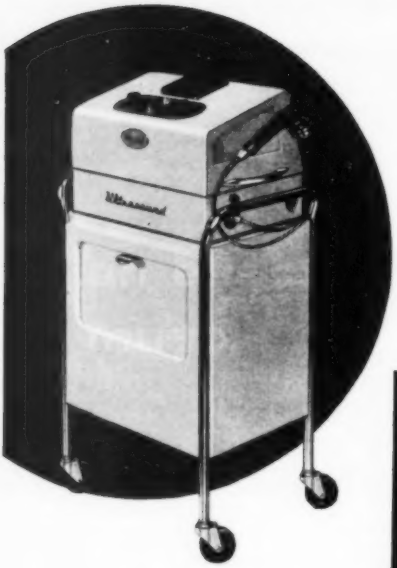
HUMOROUS COMMENTARY

INDUSTRIAL MEDICINE

INSURANCE

INVESTMENTS

LABOR UNIONS



Better and more efficient service to your patients with

The BURDICK

ULTRASONIC THERAPY UNIT

The prolonged relief from tenderness and pain which ultrasonic therapy brings to such intractable conditions as bursitis, sciatic neuralgia, spondylitis and inflammatory myalgias makes treatment with ultrasound highly gratifying to both patient and physician.

Shorter treatments required with ultrasound save time for the physician and much fatigue and discomfort for patients. Such saving can mean "better and more efficient service"* for *all* your patients.

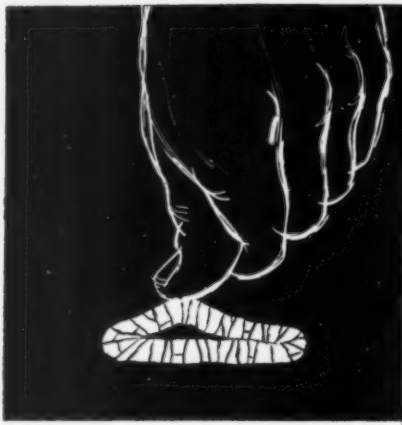
The Burdick Ultrasonic Therapy Unit is built to Burdick's usual high standards to give years of trouble-free service.

*Matlin, E.: Ultrasonics in General Practice, M. Times 83:788 (Aug.) 1955.

For a demonstration— see your Burdick dealer

For information — write us today

THE BURDICK CORPORATION — MILTON, WISCONSIN



TO COUNTERACT
corticoid-induced adrenal atrophy during corticoid therapy, *routine support* of the *adrenals with ACTH is recommended.*

THIS IS THE PROTECTIVE DOSAGE RECOMMENDATION FOR COMBINED CORTICOID-ACTH THERAPY

- When using *prednisone* or *prednisolone:*
for every 100 mg. given, inject approximately 100 to 120 units of HP*ACTHAR *Gel.*
- When using *hydrocortisone:*
for every 200 to 300 mg. given, inject approximately 100 units of HP*ACTHAR *Gel.*
- When using *cortisone:*
for every 400 mg. given, inject approximately 100 units of HP*ACTHAR *Gel.*

Discontinue administration of corticoids on the day of the HP*ACTHAR *Gel* injection.

HP*ACTHAR® *Gel*

*Highly Purified (IN GELATIN)

The Armour Laboratories brand of purified adrenocorticotropic hormone—corticotropin (ACTH)

UNSURPASSED IN SAFETY AND EFFICACY
More than 42,000,000 doses of ACTH have been given

THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY • KANKAKEE, ILLINOIS

This man is on a sugar-free, low-calorie diet...

The pudding?

New **D-ZERTA,** of course!

There's nothing like a sweet dessert to pamper a patient on a diet! And new D-Zerta Pudding has all the sweetness and flavor of America's best-liked puddings.

D-Zerta Puddings (Vanilla, Chocolate or Butterscotch) are deliciously sweetened with Sucaryl® and saccharin. There are as little as 54 calories in a serving!

D-Zerta Gelatin is sugar-free, too. Just 12 calories in a serving that costs only pennies. In six flavors at food stores everywhere.

Made by the makers of Jell-O Desserts . . . for those who must watch their sugar intake.

New sugar-free D-ZERTA Puddings and Gelatin

D-Zerta and Jell-O are registered trade-marks of General Foods Corporation. ®Sucaryl-Abbott.

from disability to dexterity

Acetycol brings welcome relief quickly to the patient suffering from arthritis and related rheumatoid diseases. As Acetycol increases the range of pain-free movement, the patient, freed from the twin taskmasters of pain and rigidity, is able to resume many of his normal activities.

The sustained effect of Acetycol is based on the relationship between aspirin and para-aminobenzoic acid. A relatively low dosage of aspirin produces high salicylate blood levels in the presence of PABA. The effectiveness of Acetycol in gout or cases of a gouty nature is due to the inclusion of salicylated colchicine.

Acetycol also contains three important vitamins, often lacking in older and rheumatic patients: ascorbic acid, to prevent degenerative changes in connective tissues; thiamine and niacin, for improved carbohydrate utilization and relief of joint pain and edema.

Usual dosage – 1 or 2 tablets three or four times a day.

Each Acetycol Tablet contains:

Aspirin	325.0 mg.
Para-aminobenzoic acid	162.0 mg.
Colchicine, salicylated	0.25 mg.
Ascorbic acid	20.0 mg.
Thiamine hydrochloride	5.0 mg.
Niacin	15.0 mg.

Supplied: Bottles of 100 and 500

Acetycol

TRADEMARK

to relieve rheumatic pain

WARNER-CHILCOTT

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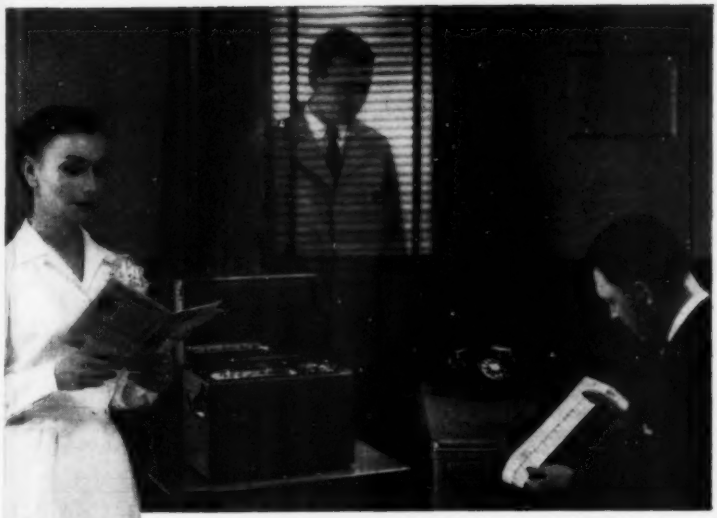

"SANBORN"
never leaves your office

A Viso-Cardiette owner finds that *service* — in many forms — is *always present*. It's just as if a Sanborn man were always standing by, ready to help him get the greatest usefulness from his Viso-Cardiette. Here are the ways Sanborn serves you:

Centrally located Sanborn Branch Office men have a *direct responsibility* towards your complete and continuing satisfaction with the Viso. They have special abilities, and complete stocks of supplies, accessories and instruments are quickly available.

Viso *designers* at the home office also may be consulted at any time on the technical aspects of special problems.

The popular, bi-monthly "Technical Bulletin" has been sent free-of-charge to owners for the past 35 years. It gives you and your technician helpful, current information on ECG and BMR testing techniques . . . typical questions and answers based on fellow-users' experience . . . facts about new Sanborn equipment and accessories.

A fourth way Sanborn serves is through advanced instruction available as correspondence courses at small cost. The thousands who have completed these courses, together with those currently enrolled, attest to their value and acceptance.

Write for descriptive literature on the Viso-Cardiette and details of a 15-day, no-obligation-to-you clinical test plan.

SANBORN COMPANY, CAMBRIDGE 39, MASS.

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she's
been
HYFRECATED*

**not a blemish on her*

Desiccate those unsightly, possibly dangerous skin growths with the ever-ready, quick and simple to use Hyfrecator. More than 100,000 instruments in daily use.

THE BIRTCHER CORPORATION

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Los Angeles 32, California

Please send me your new full-color brochure showing step-by-step technics for removal of superficial skin growths.

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Address_____

City_____ Zone____ State_____

Memo

FROM THE PUBLISHER

Long-Distance Help

A friend of mine was with the first U.S. air squadron to be sent to China during World War II. The other day, he told me a war story I'd never heard before:

"We flew in from India to the village of Yunnan-Yi, almost in Tibet. I was assigned quarters in a dilapidated Chinese hut. As I dumped my bedroll in a corner, my eye was caught by a brightly colored object. I picked it up—and found it was a September, 1941, issue of MEDICAL ECONOMICS.

"Everyone in our outfit took turns reading it. We learned a lot about doctors and their problems. We never did learn how the magazine had got there."

MEDICAL ECONOMICS' regular mailing list contains virtually no foreign addresses. But American doctors have apparently taken the magazine with them to nearly every country in the world. My friend's story is one sign of this. Another sign: the familiar-sounding requests from strange-sounding places that crop up in our mail.

In the last couple of weeks alone, for example, we have:

¶ Sent articles on office building to physicians in Lima, Peru, and in Bulawayo, Southern Rhodesia.

¶ Sent statistics to a German doctor who's making a comparative economic study of medicine there and here.

¶ Sent our portfolio on group practice to five Austrian specialists who say they're starting the first private medical group in Austria.

Such contacts seem especially rewarding when we get comments like this, from one of the Austrians: "Many thanks for the material from your journal. It's a type yournal—I'm sorry to say this—as can't be found outside your country." —LANSING CHAPMAN